



**Testimony of Melissa Wasser, Policy Counsel  
Project On Government Oversight  
before the House Committee on Veterans' Affairs  
Subcommittee on Oversight and Investigations  
on "Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?"  
May 19, 2021**

Chairman Pappas, Ranking Member Mann, and members of the subcommittee, thank you for inviting me to testify today on whistleblower protections and procedures at the Department of Veterans Affairs (VA). I am Melissa Wasser, a policy counsel at the Project On Government Oversight (POGO). POGO is a nonpartisan independent watchdog that investigates and exposes waste, corruption, abuse of power, and when the government fails to serve the public or silences those who report wrongdoing. We champion reforms to achieve a more effective, ethical, and accountable federal government that safeguards constitutional principles.

Whistleblowers have played a key role in highlighting instances of waste, fraud, and abuse at the VA, yet they frequently face retaliation for their disclosures while senior agency leaders face almost no accountability for their actions. Congress tried to handle the surge of VA whistleblowers who came forward to disclose the deadly secret wait lists and other problems at different VA centers by creating the Office of Accountability and Whistleblower Protection (OAWP). The effort was a good one, but the resulting office has several structural weaknesses that impede its functioning and independence. Not least among them is that the office was created without an office-specific general counsel, and therefore must rely on the VA's Office of General Counsel (OGC) to prepare disciplinary recommendations. Other structural flaws include a lack of power to implement disciplinary recommendations or corrective actions, and a lack of transparency in agency reporting about the office's actions. There are currently two pieces of legislation in the works meant to strengthen OAWP; through these, Congress has an opportunity to promote accountability and protect more whistleblowers at the VA.

### **The Role of Whistleblowers at the Department of Veterans Affairs**

Whistleblowers at the VA risk their careers every time they speak truth to power to help those who put their lives on the line to support and defend the Constitution of the United States. VA whistleblowers are heroes serving heroes.

Disclosures by VA whistleblowers have, for instance, saved patients' lives by bringing to light barriers to timely and effective medical care due to negligence or intentional misconduct, exposed officials who had perpetuated a culture of abuse for decades,<sup>1</sup> and freed up taxpayer dollars that were being misused and could instead go toward providing resources and care.

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<sup>1</sup> Donovan Slack, "Exclusive: 'The VA is two-faced.' Whistleblowers say managers are trying to silence them on veteran care," *USA Today*, June 22, 2019. <https://www.usatoday.com/story/news/politics/2019/06/22/va-health-care-workers-disciplined-reporting-veteran-problems/1480893001/>; Daniel Van Schooten, "VA Whistleblower Office

We've seen firsthand the profound and immediate impact whistleblower disclosures can have on the quality of care at the VA. Many are familiar with the wait lists at Arizona's Phoenix VA Health Care System, which were brought to light by VA whistleblowers in 2014. While the system's computer records falsely indicated that veterans were getting timely medical appointments, a secondary, accurate wait list reflected the prolonged wait times the veterans were experiencing. That secondary list showed that approximately 1,400 veterans were waiting months to meet with a doctor. At least 40 veterans died waiting for care.<sup>2</sup> Unfortunately, this misconduct is not an isolated incident. Complaints of inaccurate VA wait lists can be traced back over a decade and all over the country,<sup>3</sup> and even after the Phoenix scandal, the abuse persisted. Secret wait lists for care were found in Omaha in 2017<sup>4</sup> and alleged nationwide in 2019.<sup>5</sup> Whistleblowers were essential in bringing those abuses to light.

After the 2014 Phoenix VA scandal, POGO teamed up with Iraq and Afghanistan Veterans of America to encourage more VA whistleblowers to share with us their inside perspective and to help us better understand the issues the department was facing.

In POGO's 40-year history, we have never received as many submissions from a single agency. Nearly 800 current and former VA employees and veterans contacted us. We received credible submissions from 35 states and the District of Columbia.<sup>6</sup> A recurring and fundamental theme became clear: VA employees across the country feared they would face retaliation if they dared to raise a dissenting voice to the department.

Technically, most whistleblowers are legally protected. Still, they often face retaliation, and because it is so rampant, maintaining anonymity is one of the best ways for whistleblowers to protect themselves from professional and personal retaliation. Congress created the VA's Office of Accountability and Whistleblower Protection in an attempt to aid department whistleblowers in their efforts to hold the department to account. However, it appears that the office is not doing

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Wasted \$300,000 on 'Useless' Training," Project On Government Oversight, October 24, 2019.

<https://www.pogo.org/investigation/2019/10/va-whistleblower-office-wasted-300-000-on-useless-training/>

<sup>2</sup> Scott Bronstein, Drew Griffin, and Nelli Black, "Phoenix VA officials put on leave after denial of secret wait list," CNN, May 1, 2014. <http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/>

<sup>3</sup> Rich Gardella and Talesha Reynolds, "Memos Show VA Staffers Have Been 'Gaming System' for Six Years," *NBC News*, May 13, 2014. <https://www.nbcnews.com/storyline/va-hospital-scandal/memos-show-v-a-staffers-have-been-gaming-system-six-years-n104621>

<sup>4</sup> Steve Liewer, "Nebraska-Western Iowa VA kept secret waiting list for some mental health appointments," *World Herald*, October 16, 2017. [https://www.omaha.com/news/military/nebraska-western-iowa-va-kept-secretwaiting-list-for-some/article\\_c428a382-320c-560d-bbee-eb0a40ee6b23.html](https://www.omaha.com/news/military/nebraska-western-iowa-va-kept-secretwaiting-list-for-some/article_c428a382-320c-560d-bbee-eb0a40ee6b23.html); Steve Liewer and Joseph Morton, "Secret waitlist delayed care for 87 veterans at VA hospital in Omaha, led to departure of 2 employees," *World Herald*, October 31, 2017. [https://www.omaha.com/livewellnebraska/health/secret-waitlist-delayed-care-forveterans-at-va-hospital-in/article\\_5048df5a-bb65-11e7-932b-af5b8746deef.html](https://www.omaha.com/livewellnebraska/health/secret-waitlist-delayed-care-forveterans-at-va-hospital-in/article_5048df5a-bb65-11e7-932b-af5b8746deef.html)

<sup>5</sup> Joe Davidson, "Whistleblower says there's a secret VA wait list for care. The department says that's not true.," *Washington Post*, June 3, 2019. [https://www.washingtonpost.com/politics/whistleblower-says-theres-a-secret-va-wait-list-for-care-the-department-says-thats-not-true/2019/06/01/197e59a2-83df-11e9-bce7-40b4105f7ca0\\_story.html](https://www.washingtonpost.com/politics/whistleblower-says-theres-a-secret-va-wait-list-for-care-the-department-says-thats-not-true/2019/06/01/197e59a2-83df-11e9-bce7-40b4105f7ca0_story.html)

<sup>6</sup> *Addressing Continued Whistleblower Retaliation Within VA: Hearing before the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations*, 114<sup>th</sup> Cong. (April 13, 2015) (statement for the record by Lydia Dennett, Project On Government Oversight). <https://www.pogo.org/testimony/2015/04/pogo-provides-statement-for-house-hearing-on-va-whistleblowers/>

its job well in that regard.

For example, recent reporting highlights how the office retaliated against Anthony Everett, a whistleblower leading the security team that protects senior VA officials. In October 2020, Mr. Everett reported to OAWP what he viewed as an ethical breach and a misuse of taxpayer money by two senior VA officials, then-Acting Deputy Secretary Pamela Powers and then-chief of human resources Daniel Sitterly. His disclosure was supposed to be kept confidential. Just three hours after Everett made his disclosure, Ms. Powers demoted him with no reason given.<sup>7</sup>

A 2020 POGO investigation uncovered even more misconduct by top political appointees at the VA. A whistleblower complaint accused then-Secretary Robert Wilkie and his top aides of actions that “run contrary to the law and represent an abuse of authority.”<sup>8</sup> Wilkie installed Sitterly, who was under investigation by OAWP at the time, to be second-in-command of the office, despite the fact that then-Assistant Secretary for Accountability and Whistleblower Protection Tamara Bonzanto had already conducted a search for candidates and selected one to fill the position. Sitterly was installed over her objections. According to POGO’s sources, he repeatedly asked the office’s staff about specific whistleblower cases, whether employees he identified by name had made whistleblower disclosures, and whether any whistleblower disclosures implicated senior VA officials. Other leaders within OAWP reportedly replied that, for privacy and confidentiality reasons, such information could not be released, yet he persisted in making those requests.<sup>9</sup>

The complaint about Wilkie also cited an exchange regarding the role of whistleblowers at OAWP between Powers and Bonzanto. According to the complaint, Bonzanto told Powers that employees have a right to raise concerns, to which Powers replied, “Yes, but we also have to protect the Secretary,” and that we “have a lot of problematic employees in OAWP.”<sup>10</sup>

The agency’s repeated attempts to undermine or otherwise have undue influence over OAWP speaks to the need for the office’s greater independence from the agency. In the past, VA employees have reported similar improper coordination between OAWP and the VA.<sup>11</sup> Removing the bias of the agency from this equation would help better prevent retaliation, protect whistleblowers, and hold more senior officials accountable for misconduct.

## **The Office of Accountability and Whistleblower Protection**

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<sup>7</sup> Lisa Rein, “Biden’s new VA chief inherits oversight office from Trump viewed as abetting corruption,” *Washington Post*, February 18, 2021. [https://www.washingtonpost.com/politics/biden-mcdonough-va-whistleblower-trump-2021/02/16/072bab0e-5ced-11eb-b8bd-ee36b1cd18bf\\_story.html](https://www.washingtonpost.com/politics/biden-mcdonough-va-whistleblower-trump-2021/02/16/072bab0e-5ced-11eb-b8bd-ee36b1cd18bf_story.html)

<sup>8</sup> Adam Zagorin and Nick Schwellenbach, “Protect the Secretary’: VA Chief Robert Wilkie Installs Political Aide at Watchdog Investigating His Inner Circle,” Project On Government Oversight, Dec. 16, 2020. <https://www.pogo.org/investigation/2020/12/protect-the-secretary-va-chief-robert-wilkie-installs-political-aide-at-watchdog-investigating-his-inner-circle/>

<sup>9</sup> Adam Zagorin and Nick Schwellenbach, “Protect the Secretary” [see note 8].

<sup>10</sup> Adam Zagorin and Nick Schwellenbach, “Protect the Secretary” [see note 8].

<sup>11</sup> Eric Katz, “VA Office Meant to Protect Whistleblowers Actually Helped Retaliate Against Them, IG Finds,” *Government Executive*, October 24, 2019. <https://www.govexec.com/management/2019/10/va-office-meant-protect-whistleblowers-actually-retaliated-against-them-ig-finds/160847/>

In April 2017, then-President Donald Trump issued Executive Order 13793 to establish the Office of Accountability and Whistleblower Protection.<sup>12</sup> Congress later codified and expanded on the order through the VA Accountability and Whistleblower Protection Act.<sup>13</sup>

A merging of VA's Office of Accountability Review and the Central Whistleblower Office, the new accountability and whistleblower protection office was designed to be an internal fact-finding body that would:

improve the performance and accountability of VA senior executives and employees through thorough, timely, and unbiased investigation of all allegations and concerns. Where these actions are found factually true, OAWP will provide recommended actions related to the Senior Executive or other senior leader's removal, demotion or suspension based on poor performance and/or misconduct. Additionally, OAWP provides protection of valued VA whistleblowers against retaliation for their disclosures under the whistleblower protection provisions of 38 U.S.C. section 714.<sup>14</sup>

As of this year, the office was supported by 105 employees.<sup>15</sup>

The office also receives whistleblower disclosures from VA employees and applicants for VA employment alleging a violation of law, rule, or regulation; gross mismanagement, gross waste of funds, abuse of authority; or substantial and specific danger to public health or safety.<sup>16</sup>

If a disclosure involves misconduct or poor performance by a senior VA leader or whistleblower retaliation by a VA supervisor, OAWP will investigate the matter itself.<sup>17</sup> Once the office interviews a complainant to identify allegations and witnesses and develops an investigation plan, they conduct an investigation and draft a report of investigation. Once that is finalized, the office may then recommend disciplinary or other action if it is warranted to the VA component.

Whistleblower disclosures that are not within OAWP's mandate are referred for investigation to another VA office, such as the VA's Office of the Medical Inspector, the Veterans Health Administration, or the Veterans Benefits Administration. When referring a case to another office for investigation, OAWP identifies allegations and which witnesses should be interviewed. If a whistleblower requests anonymity for the referral, the office will work to ensure that the disclosure is referred anonymously. The VA office that receives the referral then prepares a

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<sup>12</sup> Executive Order 13793, "Improving Accountability and Whistleblower Protection at the Department of Veterans Affairs," April 27, 2019. <https://www.federalregister.gov/documents/2017/05/02/2017-08990/improving-accountability-and-whistleblower-protection-at-the-department-of-veterans-affairs>

<sup>13</sup> 38 U.S.C. § 323 (2021).

<sup>14</sup> Department of Veterans Affairs, *Report to The Committee on Veterans Affairs of the Senate and The Committee on Veterans Affairs of the House of Representatives on the Activities of the Office of Accountability and Whistleblower Protection, For the Period: June 30, 2017 – June 30, 2018* (July 2018), 3. <https://federalnewsnetwork.com/wp-content/uploads/2018/07/ANNUAL-REPORT-Office-of-Accountability-and-Whistleblower-Protections-Activities.pdf>

<sup>15</sup> Conversation between POGO and OAWP, May 3, 2021.

<sup>16</sup> 38 U.S.C. § 323(c)(1)(D) (2021).

<sup>17</sup> 38 U.S.C. § 323(c)(1)(H) (2021).

report of investigation and submits it to OAWP.<sup>18</sup> OAWP then works in consultation with the VA Office of General Counsel to draft a recommendation for disciplinary or other action if warranted.<sup>19</sup>

This structure can cause problems. Although OAWP and the OGC are both housed within the VA, their interests are not the same. OGC's mandate is to represent the best interests of their client: the VA. POGO has found department general counsels often believe their job is to protect the public's perception of the department, future funding, and individual jobs of senior leaders, rather than to protect the public's interest by ensuring effective execution of the department's mission. OAWP, on the other hand, is charged with fact-finding and analysis independent of any agenda to keep the agency out of legal trouble. Allowing agency attorneys to provide legal analysis or to review proposed disciplinary actions is akin to a judge allowing the defense attorney in a criminal case to overturn the judge's decision against a defendant. It's entirely inappropriate for OGC to be able to weigh in on a whistleblower retaliation complaint or other allegations of senior leader misconduct. The chance of improper consultation is too high and puts whistleblowers at a severe disadvantage. Even the appearance of a conflict on the part of OGC undermines OAWP's independence and its effectiveness across the board.

POGO warned two years ago in our previous appearance before this subcommittee that the OAWP was not functioning as intended.<sup>20</sup> While the office has improved to some degree, there are still areas in need of improvement. This office has now had over three years to translate submission intake into disciplinary action against senior VA officials found to have retaliated against VA whistleblowers. Within the last year, the office investigated more than 350 cases and referred and maintained oversight of more than 440 cases referred to VA Administrations and Staff Offices. However, the work of the office has not resulted in accountability. Although it has made 99 recommendations to address substantiated wrongdoing since April 2020, the VA has only implemented approximately half of those recommendations.<sup>21</sup>

Currently, OAWP does not have the authority to enforce disciplinary recommendations or corrective actions that the VA chooses not to implement. This lack of enforcement power is troubling. Because nearly half of OAWP's disciplinary and corrective action recommendations aren't being implemented, the VA is sending a message to its officials that they can act with

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<sup>18</sup> Department of Veterans Affairs Office of Accountability and Whistleblower Protection, *Report to The Senate Committee on Veterans' Affairs and The House Committee on Veterans' Affairs on the Activities of the Office of Accountability and Whistleblower Protection, For the Period October 1, 2018 – May 31, 2020* (May 2020), 6.

[https://federalnewsnetwork.com/wp-content/uploads/2020/08/082620\\_oawp\\_congressreport\\_FNN.pdf](https://federalnewsnetwork.com/wp-content/uploads/2020/08/082620_oawp_congressreport_FNN.pdf)  
<sup>19</sup> Department of Veterans Affairs Office of Inspector General, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, Report #18-04968-249 (October 24, 2019), 6.  
<https://www.va.gov/oig/pubs/VAOIG-18-04968-249.pdf>

<sup>20</sup> Rebecca Jones, "Whistleblower Retaliation at the Department of Veterans Affairs," Project On Government Oversight, June 25, 2019. <https://www.pogo.org/testimony/2019/06/whistleblower-retaliation-at-the-department-of-veterans-affairs/>; Daniel Van Schooten, "'Terrified' of Retaliation Inside Veterans Affairs Whistleblower Office," Project On Government Oversight, March 5, 2020. <https://www.pogo.org/investigation/2020/03/terrified-of-retaliation-inside-veterans-affairs-whistleblower-office/>

<sup>21</sup> OAWP made 40 disciplinary recommendations for senior leader misconduct, 29 recommendations for whistleblower retaliation, and 30 corrective actions since April 2020. Appendix A, 7, 8; Conversation between POGO and OAWP staff, May 3, 2021.

impunity, especially when it involves senior leader misconduct or retaliation against whistleblowers.

A path to enforcement is absolutely necessary to ensure better accountability at the VA. Senior leader misconduct and whistleblower retaliation should never be occurring at the VA, but when it does, people need to face consequences for their improper actions. The Strengthening VA Whistleblower Protection Act of 2021, a bill that would establish an OAWP-specific general counsel, could be significantly strengthened by providing a referral option for OAWP to transfer a case to the Office of Special Counsel (OSC) for disciplinary prosecution if VA components do not implement the disciplinary recommendations or corrective actions.<sup>22</sup> This would be in line with similar referral processes by inspector general offices and the Equal Employment Opportunity Commission.<sup>23</sup>

An additional problem is that there is a lack of transparency around the process when VA components reject OAWP's disciplinary recommendations. Under OAWP's authorizing statute, if a VA component decides not to implement or initiate the recommended disciplinary or corrective action within 60 days, that component is required to notify the secretary of Veterans Affairs. The secretary then submits a report to the House and Senate Committees on Veterans' Affairs documenting the disciplinary actions that were not implemented. The secretary is also required to report "a detailed justification for not taking or initiating such disciplinary action."<sup>24</sup>

Unfortunately, the reports the VA has submitted to date have been uninformative. It is not enough for Congress to get a generic report stating that OAWP had recommended discipline, that the recommendation was not implemented, a general reason it was not implemented, and the offending official's job title. For Congress to be able to conduct any meaningful oversight, the reports should also provide such relevant information as a summary of OAWP's findings, the name of the senior official who was found guilty of misconduct, where the official works, and if the official has a history of misconduct. A discussion draft bill that would amend Title 38 to strengthen and improve OAWP includes some improved reporting requirements, such as a full and substantive analysis of the activities of the office; the identification of any issues within the office; the identification of concerns around the office's size, staffing, and resources; and any potential recommendations from the head of OAWP on any legislative or administrative action. The proposed requirements are fine as written in the legislation, but a lot of them require

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<sup>22</sup> *Strengthening VA Whistleblower Protection Act of 2021*, 117th Cong. <https://docs.house.gov/meetings/VR/VR08/20210421/111431/BILLS-117StrengtheningVAWhistleblowerProtectionih.pdf>

<sup>23</sup> In 2013, the Department of Energy inspector general substantiated whistleblower retaliation claims and made a referral to OSC, which disciplined several agency officials in 2015. Josh Hicks, "Five Bonneville Power officials lost their positions over veteran-hiring scandal," *Washington Post*, April 3, 2015. <https://www.washingtonpost.com/news/federal-eye/wp/2015/04/03/five-bonneville-power-officials-lost-their-positions-over-veteran-hiring-scandal/>; The EEOC "shall refer to OSC for potential OSC enforcement action" after EEOC substantiates claims of discrimination. U.S. Equal Employment Opportunity Commission, Memorandum of Understanding Between U.S. Office of Special Counsel and Equal Employment Opportunity Commission, <https://www.eeoc.gov/mou/memorandum-understanding-between-us-office-special-counsel-and-equal-employment-opportunity>

<sup>24</sup> 38 U.S.C. § 323(f)(2) (2021).

information that is already being reported in the OAWP's annual reports, and most of them won't fix the problems that they're trying to address.<sup>25</sup>

Even OAWP's website is unhelpful. Although the office updates its website with the number of investigations, corrective actions recommended, and disciplinary recommendations issued,<sup>26</sup> it doesn't provide a public-facing number of how many disciplinary recommendations and corrective actions are actually implemented.

There are also no public-facing ways to determine where the misconduct is occurring or even what type of misconduct it is. (The whistleblower office confirmed to POGO that while the reports made to Congress aren't available publicly, we might be able receive them through Freedom of Information Act requests.<sup>27</sup> But this information should be readily available to the public without having to go through the burdensome process of filing a FOIA request.) The onus is on Congress to ensure that OAWP makes that information public, and to follow up on cases in order to hold individual senior VA leadership accountable, especially when disciplinary recommendations or corrective actions are not implemented.

Changes need to be implemented to give the Office of Accountability and Whistleblower Protection more power to ensure better enforcement of disciplinary and corrective action recommendations.

## **Recommendations**

We are encouraged to see bipartisan engagement on this effort to strengthen whistleblower protections at the VA.<sup>28</sup> OAWP was created with a laudable mission, yet it doesn't have the structure or authorities necessary to complete that mission, such as the statutory independence of an inspector general or the for-cause removal protections like the Office of Special Counsel. As a result, the office is particularly vulnerable to interference from agency leadership.

To immediately make the office more independent, Congress should mandate that it have its own office of legal counsel, circumventing any need to refer matters to the VA's Office of General Counsel. OAWP has concurred with this recommendation in the past, noting that relying on the agency's general counsel creates at the very least the appearance of a conflict of interest, and creates unnecessary delays in resolving cases.<sup>29</sup>

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<sup>25</sup> *Legislative Hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations*, 117<sup>th</sup> Cong. (April 21, 2021) (statement for the record by Melissa Wasser, Policy Counsel, Project On Government Oversight). <https://www.pogo.org/testimony/2021/04/pogo-statement-for-the-record-on-whistleblower-reforms-at-the-department-of-veterans-affairs/>

<sup>26</sup> Office of Accountability and Whistleblower Protection, "By the Numbers from April 2020 to April 2021," updated May 4, 2021. <https://www.va.gov/accountability/>

<sup>27</sup> Conversation between POGO and OAWP, May 3, 2021.

<sup>28</sup> Statement for the record by Melissa Wasser [see note 25].

<sup>29</sup> Department of Veterans Affairs, *Report to The Committee on Veterans Affairs of the Senate and The Committee on Veterans Affairs of the House of Representatives on the Activities of the Office of Accountability and Whistleblower Protection, For the Period: June 30, 2017 – June 30, 2018*, 22 (July 2018). <https://federalnewsnetwork.com/wp-content/uploads/2018/07/ANNUAL-REPORT-Office-of-Accountability-and-Whistleblower-Protections-Activities.pdf>

Such a structure is not unprecedented. Inspector general offices frequently rely on their own general counsel to provide independent and objective legal advice as they investigate claims against the agency. With a general counsel specifically assigned to OAWP, the office's investigators would be able to access independent legal advice without having to rely on the agency general counsel to make disciplinary or other corrective action recommendations. The Strengthening VA Whistleblower Protection Act of 2021 includes language that would create an office of general counsel for OAWP, and it should be implemented in order to ensure more independence from agency leadership.

Congress should also remedy OAWP's lack of power to implement disciplinary recommendations and corrective actions. When a VA component does not implement the recommendation themselves, OAWP should have the authority to refer that unimplemented disciplinary recommendation or corrective action to the Office of Special Counsel for a disciplinary prosecution at the Merit Systems Protection Board. This would ensure more enforcement and accountability than what's available in the current system.

Another improvement would be to create stronger reporting and transparency measures, which could help provide better insight into OAWP's activities. Congress should mandate that reports regarding senior leader misconduct and whistleblower retaliation be made publicly available online in an accessible format. These reports would be similar to other departments' inspectors general investigations into senior leader misconduct that are already publicly available. The Department of Defense Office of Inspector General, for instance, lists reports of investigations on their FOIA reading room website that include the name of the senior official, the allegations, an analysis of the allegations, and recommendations for discipline.<sup>30</sup> The Department of Justice Office of the Inspector General's website lists investigative summaries in cases involving administrative misconduct after issuing a final report of investigation to the component.<sup>31</sup> The information in these publicly available reports should be replicated at the VA when disciplinary recommendations or corrective actions are not taken.

Congress should also implement stronger reporting and transparency measures so that both Congress and the public can know what accountability looks like at the VA. The more discretion you give the VA to determine how much information to disclose, the less transparency you get. That, in turn, means less accountability for the veterans and the taxpayers. Effective reforms would ensure that the VA is not only correcting past misconduct but also preventing future misconduct.

## **Conclusion**

VA whistleblowers take the risk to blow the whistle because they believe it is their duty to speak up when they witness violations of the country's trust.<sup>32</sup> Congress has recognized the need to update protections for VA whistleblowers, but so far it has not been enough. The lesson is clear:

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<sup>30</sup> Department of Defense Office of Inspector General, "FOIA Reading Room." <https://www.dodig.mil/FOIA/FOIA-Reading-Room/?Search=Report+of+investigation> (accessed May 13, 2021)

<sup>31</sup> Department of Justice Office of the Inspector General, "Investigative Findings in Cases Involving Administrative Misconduct." <https://oig.justice.gov/reports/type/investigation> (accessed May 13, 2021)

<sup>32</sup> Rebecca Jones, "Whistleblower Retaliation at the Department of Veterans Affairs" [see note 20].



Despite the existence of OAWP, the VA continues to retaliate against whistleblowers and to bully investigators in order to quash investigations and dissent. Such actions are to the detriment of veterans and the taxpayers.

The Office of Accountability and Whistleblower Protection can and should be working more efficiently and effectively. With these suggested reforms, OAWP can become more independent from the VA, thereby ensuring an unbiased review of allegations, better protection of whistleblowers, and increased accountability for agency officials and their misconduct. POGO stands ready to work with the subcommittee to further explore how whistleblowers can be better protected at the VA. Thank you again for providing me the opportunity to testify today. I look forward to your questions.