



**Testimony of Joanna Derman, Policy Analyst  
Project On Government Oversight  
Before the House Committee on Veterans' Affairs  
Subcommittee on Oversight and Investigations  
on "Ensuring Independence and Building Trust: Considering Reforms To  
Whistleblower Protections at VA"  
June 16, 2022**

Chairman Pappas, Ranking Member Mann, and members of the subcommittee, thank you for the opportunity to testify on legislation under consideration today concerning the Office of Accountability and Whistleblower Protection (OAWP) at the Department of Veterans Affairs.

I am Joanna Derman, a policy analyst 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.

POGO is pleased to endorse the draft bill before this subcommittee's consideration that would reform OAWP and bring it in line with longstanding POGO recommendations, which include establishing an OAWP-specific counsel and eliminating OAWP's investigative authority.

### **The Role of Whistleblowers at the VA**

At the Department of Veterans Affairs (VA), whistleblowers heroically put their livelihoods on the line to ensure that veterans receive the best care possible. Disclosures by VA whistleblowers have not only exposed a network of systematic misconduct, medical negligence, and abuse, but also saved the lives of many patients and freed up taxpayer dollars to be put toward providing more resources to veterans in need.

In 2014, VA whistleblowers came forward to expose misconduct at a Phoenix, Arizona, VA facility. Facility managers deliberately falsified records to suggest that wait times were a reasonable length and that veterans were receiving timely care. In reality, approximately 1,400 veterans were waiting months to meet with a doctor; at least 40 of them died while waiting to be seen.<sup>1</sup> Not only were the facility managers covering their tracks to avoid oversight on the part of

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<sup>1</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/>.

the VA and its inspector general (the VA IG), but they were also using the fake waitlists to ensure they received personal performance bonuses.<sup>2</sup>

POGO responded to this scandal by working with the non-profit Iraq and Afghanistan Veterans of America to invite whistleblowers to make disclosures so that our organizations could bring the stories to light. The response we received was unprecedented in POGO's decades-long history of working with whistleblowers. In a little over a month, we received approximately 800 disclosures from current and former VA personnel as well as from veterans; the credible submissions came from over 35 states and the District of Columbia.<sup>3</sup>

The disclosures were diverse in both nature and scope. In one instance in California, a VA inpatient pharmacy supervisor was placed on administrative leave after raising concerns with his supervisors about "inordinate delays" delivering medicine to patients, including a case where a veteran's epidural drip of pain medication ran out.<sup>4</sup> In Pennsylvania, when a former VA doctor raised the alarm about physicians failing to report to the hospital, he was removed from clinical work.<sup>5</sup> In Appalachia, a VA nurse was forced out of her job when she reported concerns regarding her patients being subjected to medical neglect.<sup>6</sup>

Two things were abundantly clear. First, misconduct on the part of senior VA officials was not isolated to one facility; rather, it was a pervasive and systemic issue. Second, VA employees from across the country feared they would experience retaliation if they spoke out.

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

In 2017, then-President Donald Trump established OAWP via Executive Order 13793.<sup>7</sup> Congress codified and expanded the office that same year when it passed the Department of Veterans Affairs Accountability and Whistleblower Protection Act.<sup>8</sup> OAWP's core mission is to improve accountability at the Department of Veterans Affairs by receiving whistleblower disclosures and conducting timely, unbiased investigations into allegations of wrongdoing against VA senior executives and employees. If an allegation is substantiated, OAWP makes recommendations for disciplinary or other corrective action.<sup>9</sup>

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<sup>2</sup> Chelsea J. Carter, "Were bonuses tied to VA wait times? Here's what we know," *CNN*, May 30, 2014, <https://www.cnn.com/2014/05/30/us/va-bonuses-qa/>.

<sup>3</sup> *Addressing Continued Whistleblower Retaliation Within VA: Hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations*, 114th Cong. (April 13, 2015) (statement by the Project On Government Oversight), 1, [https://docs.pogo.org/testimony/2015/pogo\\_statement\\_on\\_va\\_whistleblower\\_retaliation\\_2015\\_04\\_13.pdf](https://docs.pogo.org/testimony/2015/pogo_statement_on_va_whistleblower_retaliation_2015_04_13.pdf).

<sup>4</sup> *Addressing Continued Whistleblower Retaliation Within VA* (statement by POGO), 1 [see note 3].

<sup>5</sup> *Addressing Continued Whistleblower Retaliation Within VA* (statement by POGO), 1-2 [see note 3].

<sup>6</sup> *Addressing Continued Whistleblower Retaliation Within VA* (statement by POGO), 3 [see note 3].

<sup>7</sup> Executive Order No. 13793 of April 27, 2017, 82 Fed. Reg. 20539-20540 (May 2, 2017), <https://www.govinfo.gov/content/pkg/FR-2017-05-02/pdf/2017-08990.pdf>.

<sup>8</sup> The Accountability and Whistleblower Protection Act, 115th Cong. (2017) <https://www.govinfo.gov/content/pkg/PLAW-115publ41/pdf/PLAW-115publ41.pdf>; 38 U.S.C. § 323 (2021).

<sup>9</sup> 38 U.S.C. § 323 (2021).

Unfortunately, it became obvious there were major problems at OAWP not long after it was established. Despite receiving nearly 2,000 submissions from whistleblowers from June 2017 to June 2018, OAWP was unable to secure any meaningful disciplinary action against VA executives or senior leadership.<sup>10</sup> In fact, over the course of OAWP's first year, only 0.1% of the disciplinary actions were taken against VA executives or senior leadership, which was on par with average levels since 2014, before the office was created.<sup>11</sup> In contrast, 36.4% of disciplinary actions within the same time frame were taken against lower-level VA employees, between GS rank 1 and GS rank 6.<sup>12</sup> As such, it is reasonable to conclude that OAWP was failing to meaningfully hold VA senior leadership accountable or spearhead the agency-wide culture change Congress and the public were demanding.

As POGO has previously testified, a major contributing reason the number of disciplinary actions against VA leadership was not higher is OAWP's lack of independence from the VA Office of General Counsel (OGC).<sup>13</sup> Currently, after OAWP develops disciplinary recommendations, it sends them over to the VA's OGC for legal review and analysis before they are finalized.<sup>14</sup> This means that the general counsel's office has ample opportunity to reject an OAWP recommendation for disciplinary action.

Even though OAWP and OGC are both components of the VA, their interests and priorities could not be further apart when it comes to accountability. POGO has found that department attorneys often believe their primary responsibility is to protect the interests and public perception of the department, the department's likelihood of receiving future

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<sup>10</sup> Department of Veterans Affairs Office of Accountability and Whistleblower Protection, *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* (June 2018), 9. <https://federalnewsnetwork.com/wp-content/uploads/2018/07/ANNUAL-REPORT-Office-of-Accountability-and-Whistleblower-Protections-Activities.pdf>.

<sup>11</sup> *Activities of the Office of Accountability and Whistleblower Protection*, 27-28 [see note 10].

<sup>12</sup> *Activities of the Office of Accountability and Whistleblower Protection*, 30 [see note 10].

<sup>13</sup> *Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?: Hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations*, 117th Cong. (May 19, 2021) (testimony of Melissa Wasser, policy counsel at POGO), <https://docs.house.gov/meetings/VR/VR08/20210519/112646/HHRG-117-VR08-Wstate-WasserM-20210519-U1.pdf>; *Learning from Whistleblowers at the Department of Veterans Affairs: Hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations*, 116th Cong. (June 25, 2019) (testimony of Rebecca Jones, policy counsel at POGO), <https://docs.house.gov/meetings/VR/VR08/20190625/109683/HHRG-116-VR08-Wstate-JonesR-20190625.pdf>; *Pending Health and Benefits Legislation: Hearing before the Senate Committee on Veterans' Affairs*, 114th Cong. (November 18, 2015) (testimony of Elizabeth Hempowicz, public policy associate at POGO), <https://www.veterans.senate.gov/services/files/991A07D9-3345-4AFF-A839-5AA3D73E32E3>; *Whistleblower Claims at the U.S. Department of Veterans Affairs: Hearing before the Senate Appropriations Subcommittee for Military Construction, Veterans Affairs, and Related Agencies*, 114th Cong. (November 6, 2015) (testimony of Lydia Dennett, investigator at POGO), <https://www.appropriations.senate.gov/imo/media/doc/110615-Dennett-Testimony1.pdf>; *Whistleblower Claims at the U.S. Department of Veterans Affairs: Hearing before the Senate Appropriations Subcommittee for Military Construction, Veterans Affairs, and Related Agencies*, 114th Cong. (July, 30, 2015) (testimony of Danielle Brian, executive director at POGO), <https://www.appropriations.senate.gov/imo/media/doc/073015%20Brian%20Testimony%20-%20POGO.pdf>.

<sup>14</sup> Government Accountability Office, *Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability*, GAO-18-137 (July 2018), 94, <https://www.gao.gov/assets/700/693268.pdf>.

funding, and individual jobs of senior leadership.<sup>15</sup> This is in stark contrast to OAWP's duty to conduct objective fact-finding, instead of ensuring the agency stays out of legal trouble. Put simply, it is often not in OGC's interest to act upon OAWP's recommendations.

While OAWP's authorizing statute prevents it from having to report to OGC, the Government Accountability Office found that the general counsel's office is nevertheless involved in OAWP's whistleblower retaliation evaluation process.<sup>16</sup> POGO has also investigated OAWP's lack of independence, reporting that there have been significant issues with leadership at the VA installing former political appointees in OAWP to protect agency prerogatives and funnel information back to the agency.<sup>17</sup>

On top of this, the VA IG issued a scathing report in 2019 which found that OAWP suffered from significant deficiencies and floundered in its mission to protect whistleblowers.<sup>18</sup> According to the watchdog, OAWP frequently misinterpreted its own statutory mandate. For example, in some instances the office investigated matters outside its authority, and in others, it referred matters it received to other VA entities — without appropriately protecting whistleblower identities — despite those matters being well within its jurisdiction and despite the direct charge to protect whistleblowers.<sup>19</sup>

Perhaps most concerning is that the VA IG found that, under former leadership, OAWP itself participated in two actions that could be considered retaliatory, which runs contrary to its own mission.<sup>20</sup> The first related to OAWP leadership's proposed removal of an employee who reported that a senior VA staffer was interfering in a disciplinary matter. The second related to OAWP's initiation of an investigation against a whistleblower.<sup>21</sup> A 2020 POGO investigation found additional examples of apparent retaliation against OAWP employees by OAWP leadership that included limiting job duties, demotion, and termination.<sup>22</sup>

While in recent years OAWP has taken steps to mitigate a number of these concerns, there is still much to be done. During this subcommittee's May 19, 2021, hearing entitled

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<sup>15</sup> *Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?* (testimony of Melissa Wasser), 5 [see note 13].

<sup>16</sup> Government Accountability Office, *Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability*, 94 [see note 14].

<sup>17</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, December 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>18</sup> Department of Veterans Affairs Office of Inspector General, *Office of Accountability & Whistleblower Protection: Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, Report #18-04968-249 (October 24, 2019), <https://www.va.gov/oig/pubs/VAOIG-18-04968-249.pdf>.

<sup>19</sup> *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act*, 20 [see note 18].

<sup>20</sup> *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act*, 53 [see note 18].

<sup>21</sup> *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act*, 53 [see note 18].

<sup>22</sup> Daniel Van Schooten, "'Terrified' of Retaliation Inside the 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>.

“Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?” Chairman Pappas recognized that OAWP leadership deserves credit for implementing the VA IG’s recommendations from 2019 by hiring needed staff, conducting educational training exercises for personnel, and significantly reducing the backlog of investigations.<sup>23</sup> POGO agrees with the chairman that this is encouraging, but we urge the committee to expeditiously pass this legislation in order to address OAWP’s larger structural issues that continue to undermine the office’s independence and ability to fulfill its important mission.

### **This Draft Legislation**

In May 2021, this subcommittee considered two bills to reform OAWP. Chairman Pappas proposed the Strengthening VA Whistleblower Protection Act of 2021 and Ranking Member Mann proposed a draft bill to amend Title 38 to strengthen and improve OAWP.<sup>24</sup> The goal coming out of that legislative hearing was to combine the two texts. This bipartisan legislation is a result of those efforts and incorporates strong provisions from both proposals.

This legislation would fix the fundamental flaws of the existing structure of the office. First and foremost, it would establish an OAWP-specific legal counsel. POGO has previously advocated for this reform, as it would immediately strengthen OAWP’s independence and allow the office to gain insight and legal advice outside of the OGC’s chain of command. This structure is not unprecedented: It is used elsewhere in the federal government where independence is critical. For example, offices of inspectors general have their own general counsel to provide unbiased and objective legal advice to make disciplinary or other corrective recommendations.<sup>25</sup>

Another improvement the bill makes is that it removes OAWP’s investigative functions. This would free up significant resources, enabling the office to issue reports, analyze data, and identify trends within the agency. Moreover, it would allow OAWP to take on a more educational role and work to promote a culture change agency-wide, one in which whistleblowers are valued as heroes rather than villains and managers understand their obligations to protect whistleblowers.

We are also encouraged to see that this bill strengthens whistleblower protections. It does so by clarifying what constitutes a prohibited personnel practice, broadening protections for senior executive service employees, and allowing whistleblowers to seek temporary relief

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<sup>23</sup> *Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?: Hearing before the House Committee on Veterans’ Affairs Subcommittee on Oversight and Investigations*, 117th Cong. (May 19, 2021), 5:41, <https://www.youtube.com/watch?v=ObxIwTUeiKs>.

<sup>24</sup> Strengthening VA Whistleblower Protection Act of 2020, H.R. 8860, 116th Cong. (2020) <https://www.congress.gov/bill/116th-congress/house-bill/8860>; To amend title 38, United States Code, to make certain improvements to the Office of Accountability and Whistleblower Protection of the Department of Veterans Affairs, and for other purposes, H.R. 6638, 117th Cong. (2022) <https://www.congress.gov/bill/117th-congress/house-bill/6638>.

<sup>25</sup> Ben Wilhelm, Congressional Research Service, *Statutory Inspectors General in the Federal Government: A Primer*, R45450, updated May 12, 2022, 3, <https://crsreports.congress.gov/product/pdf/R/R45450>.

while their cases are under investigation. For example, it ensures that the Department of Veterans Affairs secretary cannot reprimand, suspend, remove, involuntarily reassign, demote, or remove a whistleblower seeking corrective action without the approval of the special counsel. Additionally, the secretary may not take any of those actions if OAWP referred a case to another investigative entity until that office has reached a final decision.

Additionally, the bill requires OAWP to institute robust tracking mechanisms to monitor settlement agreements that the VA enters into with whistleblowers. Right now, it is not uncommon for VA whistleblowers to be stuck in settlement negotiations for extended periods of time, sometimes years, to be made whole.<sup>26</sup> Under this bill, OAWP would have the tools to ensure timely negotiations and implementation of the agreements. It would also empower OAWP to track implementation of disciplinary actions in retaliation cases. In order to keep track of this information, the bill directs the head of OAWP to work in consultation with the VA OGC — which handles settlement negotiations for the department — to establish an electronic system.

This bill would also require OAWP to provide information and special training to VA employees on whistleblower rights, whistleblower disclosures, and processes related to submitting allegations of whistleblower retaliation. Given that the VA has historically had such a difficult time cultivating an environment where whistleblowers feel safe to come forward, this requirement would help educate VA employees about their legal protections and methods of seeking recourse.

Finally, this bill improves VA reporting requirements to Congress with respect to whistleblower disclosures.

## **Conclusion**

VA whistleblowers come forward despite enormous personal and professional risk to expose instances of waste, fraud, and abuse that impact the agency's ability to serve our nation's veterans. While Congress — and this subcommittee in particular — has played a huge role in standing up OAWP, there is still much work to be done. That is why it is critical that lawmakers pass this legislation, to support whistleblowers and ensure they have the resources they need to continue holding the VA accountable to veterans and the U.S. public.

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<sup>26</sup> *An Examination of VA's Misuse of Employee Settlement Agreements: Hearing before the House Committee on Veterans' Affairs*, 114th Cong. (September 14, 2016), <https://www.govinfo.gov/content/pkg/CHRG-114hhrg25225/html/CHRG-114hhrg25225.htm>.