



**Testimony of Joe Spielberger, Policy Counsel  
Project On Government Oversight  
before the House Committee on Veterans' Affairs  
Subcommittee on Oversight and Investigations  
on "Trust in Transparency: Holding VA Accountable and Protecting Whistleblowers"  
November 2, 2023**

Chairwoman Kiggans, Ranking Member Mrvan, and members of the subcommittee, thank you for the opportunity to testify today on whistleblower protection and accountability at the Department of Veterans Affairs (VA).

I am a policy counsel at the Project On Government Oversight (POGO). POGO is a nonpartisan independent watchdog organization 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's Investigations of VA Abuse and Corruption**

Whistleblowers play a key role in exposing misconduct at the VA at great risk to themselves. Their disclosures have exposed systemic corruption, medical negligence, and abusive government actors. They have saved the lives of VA patients and safeguarded taxpayer dollars to provide better resources to veterans. Congress depends on whistleblowers in order to fully exercise its own constitutional oversight and legislative authorities. Unfortunately, whistleblowers frequently face retaliation for their disclosures while senior leaders are rarely held accountable for their actions.

In coming forward, whistleblowers risk losing their jobs, ending their careers, suffering lifelong mental and psychological hardship, and facing retaliatory lawsuits or even serious criminal charges. All this simply for speaking out to ensure their agencies fulfill their missions and maintain the public's trust. Whistleblowers deserve the safest avenues to make legal disclosures and expose wrongdoing. Agency officials who retaliate against whistleblowers both violate their legal rights and do real harm to our government and our country. These officials betray the public's trust not only by allowing corruption and abuse of power to continue, unaddressed, but by further exacerbating it. That is why it is so important to hold retaliators accountable for their actions and ensure that whistleblowers who experience retaliation have a fair shot at justice and at being made whole.

This is especially true for VA whistleblowers, whose disclosures can literally mean the difference between life and death. In 2014, whistleblowers exposed that VA hospitals were falsifying

records, keeping secret wait lists, and allowing veterans to languish for months without care.<sup>1</sup> At least 40 veterans died while waiting for appointments through the Phoenix, Arizona, VA health care system alone.<sup>2</sup> The VA's Office of the Inspector General (IG) later told the House Veterans Affairs Committee that these secret wait lists contributed to veterans' deaths.<sup>3</sup> Officials used fake wait lists and manipulated wait-list times to make them appear shorter, which reportedly allowed them to personally collect performance bonuses.<sup>4</sup> Complaints of inaccurate VA wait lists continued, and were alleged nationwide in 2019.<sup>5</sup> The IG later confirmed that wait-time data the VA relied on was inconsistent and misleading.<sup>6</sup>

Many of the whistleblowers who played a critical role in exposing these abusive practices paid with their careers. The VA placed a California pharmacy supervisor on administrative leave after he raised concerns about "inordinate delays" delivering medicine to patients. In Pennsylvania, a former VA doctor was removed from clinical work after he sounded the alarm about on-call physicians failing to report to the hospital. In Appalachia, a VA nurse was forced out of her job after reporting concerns regarding her patients being subjected to medical neglect.<sup>7</sup> POGO's 2014 investigation into the VA amid the wait-list scandal exposed what insiders called a rampant "culture of harassment," one so "full of fear and intimidation that very few employees advocate for the [v]eteran."<sup>8</sup> This culture of fear was not limited to employees, either. Sources told POGO that families of VA patients at the time reported "fear of not being able to continue receiving services, if they complain, or make concerns known."<sup>9</sup> This was a shameful dereliction of duty and catastrophic failure of the VA's core mission to care for veterans and their families and caregivers.

Congress attempted to address this scandal by establishing the VA's Office of Accountability and Whistleblower Protection (OAWP) in 2017. Congress authorized OAWP to fulfill a critically

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<sup>1</sup> VA Office of Inspector General, *Veterans Health Administration: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, 14-02603-267 (August 26, 2014), <https://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf>.

<sup>2</sup> Scott Bronstein and Drew Griffin, "A fatal waitlist: Veterans languish and die on a VA hospital's secret list," CNN, April 23, 2014, <https://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/>.

<sup>3</sup> Jim Avila, "Phoenix Wait-Lists 'Contributed' to VA Deaths," *ABC News*, September 17, 2014, <https://abcnews.go.com/blogs/politics/2014/09/phoenix-wait-lists-contributed-to-va-deaths/>.

<sup>4</sup> Quil Lawrence, "Audit Reveals Vast Scale of VA Waitlist Issues," NPR, June 9, 2014, <https://www.npr.org/2014/06/09/320375564/audit-reveals-vast-scale-of-va-waitlist-issues>.

<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> Department of Veterans Affairs Office of Inspector General, *Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data*, Memo #21-02761-125 (April 7, 2022), <https://www.va.gov/oig/pubs/VAOIG-21-02761-125.pdf>.

<sup>7</sup> *Whistleblower Claims at the U.S. Department of Veterans Affairs: Hearing before the Senate Committee on Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies* (July 30, 2015) (testimony of Danielle Brian, executive director, Project On Government Oversight), <https://www.pogo.org/testimonies/testimony-of-pogos-danielle-brian-on-whistleblower-claims-at-us-department-of-veterans-affairs>.

<sup>8</sup> Lydia Dennett, "Fear and Retaliation at the VA," Project On Government Oversight, July 21, 2014, <https://www.pogo.org/investigations/fear-and-retaliation-at-va>.

<sup>9</sup> Dennett, "Fear and Retaliation at the VA," [see note 8].

important mandate: to improve VA accountability by receiving whistleblower disclosures and investigating allegations of retaliation and wrongdoing against senior executives and supervising employees.<sup>10</sup> Prior to OAWP’s establishment, POGO and other whistleblower advocates raised concerns about housing a central whistleblower office within the agency without proper independence. While it was clear that more resources were necessary to address the rise of whistleblower complaints, POGO believed the office would not be sufficiently independent from the agency to investigate and provide accountability.<sup>11</sup> Reluctance of employees at the VA to come forward to their own inspector general indicated a culture of retaliation that likely would not be alleviated by the creation of another office with similar “independence” at the VA.<sup>12</sup>

At the time, we warned that OAWP “may well be a wolf in sheep’s clothing,” and would risk “becoming an internal clearinghouse to help agency managers identify and retaliate against whistleblowers.”<sup>13</sup> Since then, POGO has investigated and reported about conflicts of interest, waste, and whistleblower retaliation within OAWP itself.<sup>14</sup> POGO also previously warned this Subcommittee that OAWP does not operate as Congress intended, especially because of its lack of independence and inability to enforce disciplinary recommendations.<sup>15</sup>

### **OAWP’s Lack of Independence and Enforcement Authority**

Because OAWP was established without its own in-house general counsel, the office is forced to coordinate with and rely on the VA’s Office of General Counsel for legal advice and analysis

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<sup>10</sup> 38 U.S.C. § 323(c) (2023), <https://www.law.cornell.edu/uscode/text/38/323>.

<sup>11</sup> *Pending Health and Benefits Legislation: Hearing before the Senate Committee on Veterans’ Affairs* (May 17, 2017) (testimony of Liz Hempowicz, policy counsel, Project On Government Oversight), <https://www.pogo.org/testimonies/pogo-testimony-on-va-accountability-and-whistleblower-protection-act>.

<sup>12</sup> Hempowicz, *Pending Health and Benefits Legislation* [see note 11].

<sup>13</sup> Daniel Van Schooten, “POGO and Others Oppose ‘Trojan Horse’ Office for VA Whistleblowers,” Project On Government Oversight, September 30, 2016, <https://www.pogo.org/analysis/pogo-and-others-oppose-trojan-horse-office-for-va-whistleblowers>.

<sup>14</sup> Daniel Van Schooten, “‘Terrified’ of Retaliation: Inside Veterans Affairs Whistleblower Office,” Project On Government Oversight, March 5, 2020, <https://www.pogo.org/investigations/terrified-of-retaliation-inside-veterans-affairs-whistleblower-office>; 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/investigations/protect-the-secretary-va-chief-robert-wilkie-instaldvjl-political-aide-at-watchdog-investigating-his-inner-circle>; Daniel Van Schooten, “VA Whistleblower Office Wasted \$300,000 on ‘Useless’ Training,” Project On Government Oversight, October 24, 2019, <https://www.pogo.org/investigations/va-whistleblower-office-wasted-300-000-on-useless-training>.

<sup>15</sup> Rebecca Jones, “Whistleblower Retaliation at the Department of Veterans Affairs,” Project On Government Oversight, June 25, 2019, <https://www.pogo.org/testimonies/whistleblower-retaliation-at-the-department-of-veterans-affairs>; *Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?: Hearing before the House Committee on Veterans’ Affairs Subcommittee on Oversight and Investigations* (May 19, 2021) (testimony of Melissa Wasser, policy counsel, Project On Government Oversight), <https://docs.house.gov/meetings/VR/VR08/20210519/112646/HHRG-117-VR08-Wstate-WasserM-20210519-U1.pdf>; *Ensuring Independence and Building Trust: Considering Reforms To Whistleblower Protections at VA: Hearing before the House Committee on Veterans’ Affairs, Subcommittee on Oversight and Investigations* (June 16, 2022) (testimony of Joanna Derman, policy analyst, Project On Government Oversight), <https://docs.house.gov/meetings/VR/VR08/20220616/114903/HHRG-117-VR08-Wstate-DermanJ-20220616-U1.pdf>.

concerning proposed disciplinary actions against senior VA leaders.<sup>16</sup> The authorizing statute only stipulates that OAWP “shall not be established as an element of the Office of the General Counsel and the Assistant Secretary may not report to the General Counsel,” without specifying how the two offices should or should not coordinate.<sup>17</sup> However, in practice, when an OAWP investigation results in a disciplinary recommendation, OAWP drafts a recommendation in consultation with the Office of General Counsel and sends their draft to that office for legal review. OAWP then engages with Office of General Counsel attorneys and the management officials who will decide whether to sustain, mitigate, or set aside the proposed disciplinary action.<sup>18</sup>

This is a clear conflict of interest because, although OAWP and the Office of General Counsel are both housed within the VA, they have conflicting mandates and their interests are not the same. OAWP is charged with conducting objective, fact-based investigations and analysis and ensuring whistleblower disclosures are properly investigated. On the other hand, the Office of General Counsel’s mandate is to represent the best interests and meet the legal needs of its client, the VA, including limiting its legal liability. 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. It is entirely inappropriate for the Office of General Counsel 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. Agency officials can reject OAWP recommendations even if it finds senior officials engaged in misconduct or retaliation. And OAWP lacks enforcement power to implement disciplinary recommendations or corrective action that the VA chooses not to implement. Even the appearance of a conflict on the part of the Office of General Counsel undermines OAWP’s independence and effectiveness.

No internal whistleblower protection office can adequately protect whistleblowers without real independence from the agency it investigates. An office without enforcement authority is toothless, because at most it can only make recommendations to the agency. OAWP must have its own independent legal counsel, with the authority to prepare legal opinions without review or approval from the Office of General Counsel, as well as final decision-making authority for disciplinary recommendations. This structure is not unprecedented: It is used elsewhere in the federal government where independence is critical, especially at offices of inspectors general that have their own general counsel to provide unbiased and objective legal advice around disciplinary or other corrective recommendations.<sup>19</sup>

OAWP has concurred with this recommendation in the past, noting that its reliance on the agency’s general counsel causes unnecessary delays in resolving cases and creates at the very

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<sup>16</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), 6-7, <https://www.va.gov/oig/pubs/VAOIG-18-04968-249.pdf>.

<sup>17</sup> 38 U.S.C. § 323(c)(3)(e) (2023), <https://www.law.cornell.edu/uscode/text/38/323>.

<sup>18</sup> Department of Veterans Affairs Office of Inspector General, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017* [see note 16].

<sup>19</sup> Ben Wilhelm, Congressional Research Service, *Statutory Inspectors General in the Federal Government: A Primer*, R45450, updated May 12, 2022, <https://crsreports.congress.gov/product/pdf/R/R45450>.

least the appearance of a conflict of interest.<sup>20</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.

## **OAWP Retaliation**

In addition to concerns about structural independence and conflicts of interest failing to protect whistleblowers, perhaps most concerning are instances where OAWP has been the *source* of retaliation.<sup>21</sup> Reporting in 2020 showed that OAWP retaliated against Anthony Everett, a whistleblower leading the security team that protects senior VA officials. 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. Everett's disclosure was supposed to be kept confidential, but just three hours after he made his disclosure, Powers demoted him with no reason given.<sup>22</sup>

Shortly thereafter, then-VA Secretary Robert Wilkie installed Sitterly, who was under investigation by OAWP at the time, to be second-in-command of the office. This was over the objections of then-Assistant Secretary for Accountability and Whistleblower Protection Tamara Bonzanto, who had already conducted a search for candidates and selected one to fill the position. According to POGO's sources, Sitterly repeatedly asked the office's staff about specific whistleblower cases, including 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. A whistleblower complaint about Wilkie also cited an exchange between Powers and Bonzanto regarding the role of whistleblowers at OAWP. 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 there are "a lot of problematic employees in OAWP."<sup>23</sup>

Additionally, VA employees have reported similar improper coordination between OAWP and the VA. This includes OAWP wrongfully referring whistleblower retaliation cases to other department components despite having jurisdiction, including to "the very facilities or network offices where the complainant worked or that were the subject of the allegations," and requiring whistleblowers to consent to OAWP releasing their identities before investigating or referring their case, in direct conflict with OAWP's responsibility to keep whistleblowers' identities

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<sup>20</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), [ANNUAL-REPORT-Office-of-Accountability-and-Whistleblower-Protections-Activities.pdf](#).

<sup>21</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-protectwhistleblowers-actually-retaliated-against-them-ig-finds/160847/>.

<sup>22</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>23</sup> Zagorin and Schwellenbach, "'Protect the Secretary'" [see note 14].

confidential.<sup>24</sup> The VA's repeated attempts to undermine or otherwise assert undue influence over OAWP speaks to the need for the office's greater independence from the agency.

### **OAWP's Failure to Hold Senior Leaders Accountable**

Another key part of OAWP's mandate is to investigate misconduct of senior leaders, but early results demonstrate OAWP's failure to hold high-ranking officials accountable. 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. In fact, over the course of OAWP's first year of operation, only 0.1% of disciplinary actions were taken against VA executives or senior leadership, a figure on par with the years prior to the office's creation. 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>25</sup>

This failure led to the Office of Inspector General's scathing 2019 report, which found "significant deficiencies" in how the VA Accountability and Whistleblower Protection Act was being implemented and that OAWP had "floundered in its mission to protect whistleblowers."<sup>26</sup> The report even found that in some cases, OAWP investigations were instruments of retaliation.<sup>27</sup> Despite this, accountability was scarce. From June 23, 2017, to March 22, 2019, officials involved in covered executive disciplinary actions (proposing, deciding, or grievance officials) mitigated the discipline recommended by OAWP in 32 of the 35 covered executive cases that proceeded to a final decision. OAWP's recommendation was accepted only three times.<sup>28</sup>

During a 2022 subcommittee hearing on this topic, then-Subcommittee Chair Chris Pappas (D-NH) reported that in 2021 OAWP made 15 disciplinary recommendations against senior leaders who retaliated, but the VA acted on only five, and only fully implemented one.<sup>29</sup> Then-Ranking Member Tracey Mann (R-KS) reported that an investigation into a senior official found that they did retaliate, and even though OAWP recommended discipline and the VA agreed, it was never carried out: The report was allegedly delayed for more than a year, then finalized the same week the individual retired. As Representative Mann analogized, "The fox is guarding the hen house,

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<sup>24</sup> Eric Katz, "VA Office Meant to Protect Whistleblowers Actually Helped Retaliate Against Them, IG Finds," [see note 21]; Department of Veterans Affairs Office of Inspector General, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, ii [see note 16].

<sup>25</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* [see note 20].

<sup>26</sup> Department of Veterans Affairs Office of Inspector General, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, ii [see note 16].

<sup>27</sup> Department of Veterans Affairs Office of Inspector General, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, iv, 53 [see note 16].

<sup>28</sup> Department of Veterans Affairs Office of Inspector General, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, 37 [see note 16].

<sup>29</sup> *Ensuring Independence and Building Trust: Considering Reforms to Whistleblower Protections at VA: Hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations*, 117th Cong. (June 16, 2022), [https://www.youtube.com/watch?v=RzdMvL\\_vb\\_w](https://www.youtube.com/watch?v=RzdMvL_vb_w).

and it's time for a change.”<sup>30</sup> Without more accountability, the VA sends a message to its officials that they can act with impunity, especially regarding senior leader misconduct and whistleblower retaliation.

## **Recent Improvements**

OAWP leadership deserves credit for implementing recommendations from the 2019 report from the Office of the Inspector General, including hiring needed staff, conducting educational training exercises, and significantly reducing the backlog of investigations. However, OAWP's larger structural issues continue to undermine the office's independence and ability to fulfill its important mission and mitigate retaliation.

The Office of Special Counsel continues to receive far more cases from VA employees than any other agency, a majority of which (69%) involve alleged whistleblower retaliation.<sup>31</sup> The percentage of favorable actions in VA whistleblower retaliation cases at the Office of Special Counsel increased from 3% in fiscal year 2018 to 10% in FY 2022. However, while the total number of VA whistleblower retaliation cases has generally decreased over the last five years, the proportion of VA cases of prohibited personnel practices that include a whistleblower retaliation allegation has generally increased.

Finally, while we are hopeful about improvements that new OAWP leadership has made to the culture of whistleblowing at the VA, any such improvements can easily be undone by future leadership and are no substitute for the structural reforms that OAWP needs.

## **Ensuring Due Process**

We appreciate the bipartisan commitment to holding senior leaders accountable for retaliation and other misconduct and the urgency to address this issue. At the same time, accountability must include necessary due process rights for all VA employees. Any departure from that due process sets the agency up for further scandal, low morale, and mission failure. Streamlining removal processes may be one way to rid the agency of bad actors, but it should not come at the cost of stripping hard-fought workplace protections from all employees, including whistleblowers themselves.

Without independence from their parent agencies, self-policing entities will continue to protect senior leaders while facilitating the removal of lower-level employees, placing whistleblowers at further risk of retaliation. Stripping civil service protections is a surefire way to curtail whistleblowing, because employees who are already vulnerable to retaliation will face increased obstacles to coming forward. But if, on the contrary, employees have full civil service

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<sup>30</sup> *Ensuring Independence and Building Trust: Hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations* [see note 29].

<sup>31</sup> Office of Special Counsel, *Annual Report to Congress for Fiscal Year 2023*, (June 26, 2023), <https://osc.gov/Documents/Resources/Congressional%20Matters/Annual%20Reports%20to%20Congress/FY%202022%20Annual%20Report%20to%20Congress.pdf>; Government Accountability Office, *VA Whistleblowers: Resolution Process for Retaliation Claims*, GAO-23-106111 (2023), <https://www.gao.gov/assets/gao-23-106111.pdf>.

protections and safe avenues to report wrongdoing, it will empower more whistleblowers to speak out and expose misconduct, ensuring the VA can better fulfill its mission of serving veterans and their families. The path to better accountability is to provide for OAWP's independence from the agency; ensure that senior leaders' misconduct is swiftly and properly investigated; authorize OAWP to enforce disciplinary recommendations; and ensure that whistleblowers are protected and, when faced with retaliation, have a fair shot to prevail on the merits of their claims and to be made whole.

POGO is pleased to see this subcommittee engaging on whistleblower policy. We encourage Congress to act expeditiously to provide OAWP with its own independent legal counsel with final determination for disciplinary recommendations and enforcement authority to ensure that the VA holds senior leaders accountable for retaliation and other misconduct. With these suggested reforms, OAWP can become more independent, better protect whistleblowers, ensure unbiased reviews of allegations, and bring about more accountability for agency officials.

Thank you again for inviting me to testify before you today. POGO is committed to working closely with this subcommittee to enact these recommendations and further explore how Congress can better protect VA whistleblowers and ensure senior leaders are held accountable for their actions.