DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

JUN - 5 2018

Mr. Peter O'Rourke
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Acting Secretary O'Rourke:

The Office of Inspector General (OIG) is deeply concerned by the failure of the Office of Accountability and Whistleblower Protection (OAWP) to provide information that has been requested in multiple in-person meetings with you and others at VA over the last six months. As you are aware, beginning in November 2017, the OIG has attempted on numerous occasions to obtain access to complaints filed with OAWP. Despite repeated assurances that these records would be made available, the OIG has not yet been provided this important information.

Under the Inspector General Act of 1978, 5 U.S.C. App 3, § 6(a)(1), the OIG is authorized to have access "to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to the [VA] which relate to programs and operations with respect to which that Inspector General has responsibilities under [the] Act." Further, the Act provides that this broad authority applies "notwithstanding any of other provision of law," except where Congress has expressly limited the Inspector General's access. *Id.* Thus, the Department has no basis to withhold any record from the OIG, including OAWP materials. Refusing to provide this information not only violates the law, but also hinders the OIG's ability to fulfil its statutory oversight function.

Although the OIG does not need to provide a reason to obtain information, we informed you and others at VA of the more significant reasons why obtaining information about complaints received by the OAWP is necessary to our work. First, it is important to know whether the OAWP is working on a complaint that has also been referred to the OIG. Particularly if it involves a criminal matter, it is critically important that the OAWP not conduct parallel work on the matter as it could negatively impact any potential prosecution. Second, Federal regulations governing VA require the Department immediately to refer criminal matters involving felonies to the OIG, including, but not limited to, "theft of Government property over $1000, false claims, false statements, drug offenses, crimes involving information technology systems and serious crimes against the person, i.e., homicides, armed robbery, rape, aggravated assault and serious physical abuse of a VA patient." 38 C.F.R. § 1.204. The OIG wants to ensure that all relevant

matters have been referred to it. Third, the statute creating OAWP specifically mandates referral to the Office of the Medical Inspector, the OIG, or other appropriate investigative entity where there is "reason to believe the whistleblower disclosure is evidence of a violation of a provision of law, mismanagement, gross waste of funds, abuse of authority, or a substantial and specific danger to public health or safety." Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, P.L. 115–41, § 323(c)(1)(D). Given that OAWP has informed the OIG that since its inception OAWP has received an average of 150 to 170 whistleblower complaints per month, it does not appear that an appropriate number of complaints have been referred to the OIG.

Unless the OIG is provided with the requested information regarding complaints received by OAWP by Tuesday, June 12, 2018, I will have no choice but to report this failure to comply with repeated requests for information to the relevant Committees in Congress. I thank you for your consideration and look forward to hearing from you.

Sincerely

MICHAEL J. MISSAL

Copy to: The Honorable Thomas Bowman, Deputy Secretary

**THE SECRETARY OF VETERANS AFFAIRS**
**WASHINGTON**

The Honorable Michael Missal
Inspector General
U. S. Department of Veterans Affairs

Dear Mr. Missal:

I am in receipt of your June 5, 2018 letter addressed to me as the Acting Secretary of Veterans Affairs. I surmise your letter is sent pursuant to section 6(b)(2) of the IG Act because you believe a component of VA has unreasonably refused or not provided requested information. You allege in your letter that the Office of Accountability and Whistleblower Protection (OAWP) has failed "to provide information that has been requested in multiple in-person meetings with [me] and others at VA over the last six months." You also stated in your letter that "repeated assurances" were given that OIG would be granted access to complaints filed with OAWP.

OAWP, a component of the Department of Veterans Affairs like OIG, has found no specific requests for information from OIG that have been denied. Your broad request that appears to seek unrestricted and continuous access to OAWP case intake and triage is neither "practicable" nor appropriate. Your assertion that "it does not appear that an appropriate number of complaints have been referred to the OIG" infers some ill intent by OAWP that contradicts the continuous interaction between OAWP and OIG staff. The lack of cooperation from the OIG Hotline staff and leadership to protect VA Whistleblowers and resolve complaints and disclosures across the VA is promoting the flawed culture the VA Accountability and Whistleblower Protection Act was meant to address. Furthermore, absent a specific request for information, OAWP is unable to determine whether the information you seek relates to the programs and operations with respect to which the IG has responsibilities under the IG Act.

Ironically, your letter does not address the data that should be provided to OAWP by OIG consistent with the VA Accountability Act. Specifically, OIG is mandated to provide OAWP with timely data from telephone hotlines, other whistleblower disclosures, and audits and investigations relevant to fulfilling OAWP's mandated requirement to analyze such data to identify trends and issue reports to me and the Congress based on such analysis and conclusions. OAWP is also required by law to record, track, review and confirm implementation of OIG audits and investigations and cannot do so without information and cooperation from your office.

Recently discovered OIG unrestricted and continuous access to GCLaws (Office of General Counsel restricted document and legal advice system of records) is an unacceptable example of OIG improper overreaching and abuse of authority. Fortunately, upon discovery by

OGC, you and our General Counsel were able to immediately remediate and take corrective action regarding this breach of duties and potential damage to VA's important attorney-client privilege protections.

I am also troubled by OIG not performing its responsibilities in a fair and objective manner which has caused significant harm to the reputation and performance of VA and its employees. The Inspector General Reform Act of 2008 (IG Reform Act) provides that members of the Council of the Inspectors General on Integrity and Efficiency (CIGIE) "shall adhere to professional standards developed by the Council" (§ 11(c)(2) of the IG Reform Act). Specifically, due professional care must be used in conducting investigations and in preparing related reports. Unfortunately, the VA OIG has significantly deviated from this standard in ways that have materially harmed the VA and its employees.

OIG has repeatedly failed to demonstrate due professional care "in conducting investigations and in preparing related reports." Council of the Inspectors General on Integrity and Efficiency (CIGIE) Quality Standards for Investigations. Among the requirements adopted by CIGIE for this standard the VA OIG has failed to adhere to include: thoroughness, legal requirements, appropriate techniques, impartiality, objectivity, timeliness, and, accurate and complete documentation. There are several disturbing examples of OIG investigative reports that improperly and recklessly cast the VA and its employees in an unfavorable light and demonstrate clear investigative misconduct and neglectful senior executive oversight. Examples include reports where the underlying evidence or lack thereof does not support the report's conclusions; evidence is gathered through highly improper, highly suggestive, and highly unreliable techniques; and, pursuing possible exculpatory evidence is ignored or exculpatory evidence that contradicts your chosen narrative is intentionally excluded.

You also appear to misunderstand the independent nature of your role and operate as a completely unfettered autonomous agency. You are reminded that OIG is loosely tethered to VA and in your specific case as the VA Inspector General, I am your immediate supervisor. You are directed to act accordingly.

Sincerely,

Peter O'Rourke

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

JUN 18 2018

The Honorable Tim Walz
Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Walz:

I am writing to notify you of a current dispute between the Acting Secretary of the Department of Veterans Affairs and the Office of Inspector General (OIG) concerning the Department's refusal to provide the OIG with requested information necessary for us to perform our oversight work. Specifically, since November 2017, and despite repeated requests, the Department has not provided the OIG with access to the Office of Accountability and Whistleblower Protection (OAWP) complaint database. The OIG is required to report in our semiannual report to Congress on incidents in which we are restricted from or significantly delayed in obtaining access to information needed to conduct our oversight work. Because our next semiannual report will not be published until the end of November 2018, we are bringing this to your attention now in an effort to resolve the impasse and move forward with our oversight work.

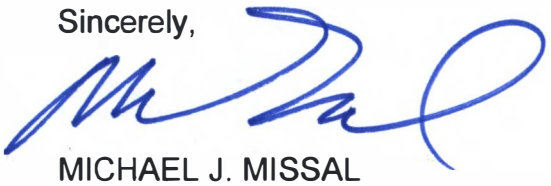
As you are aware, OAWP was formed last year by the *Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017* (Public Law 115–41). One of the stated purposes of OAWP is to receive whistleblower disclosures and to refer those disclosures to an appropriate office, including the OIG, for investigation. Given the potential for overlap between the complaints made to OAWP and complaints to the OIG Hotline, the attendant waste of government resources if OAWP and OIG duplicate investigations, and the OIG's responsibility for investigating all potential criminal matters involving the Department, the OIG has for more than seven months sought to work out a process with OAWP to obtain access to its complaint database. As discussed in the attached correspondence, the OIG needs this information to promote efficiency and to ensure that all serious allegations of wrongdoing involving the Department and its leadership are appropriately investigated.

Unfortunately, the OIG's requests to OAWP for access to this information have not been granted. We enclose for your information our recent correspondence with Acting VA Secretary Peter O'Rourke on this matter. Given the lack of responsiveness to repeated OIG requests, I believe you should be notified so that you may take whatever action you deem appropriate.

Our access to this information is more critical at this time, as we have received a request on June 15, 2018, from the Senate Committee on Veterans Affairs Ranking Member Jon Tester and Senator Richard Blumenthal, Senator Tammy Baldwin, and Senator Sherrod Brown to examine the perceived inadequacy of the Department's mandated reporting of its OAWP operations.

Thank you for your attention to this important matter.

Sincerely,



MICHAEL J. MISSAL

Enclosures