



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Special Reviews

OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER
PROTECTION

Failures Implementing
Aspects of the VA
Accountability and
Whistleblower Protection
Act of 2017



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Executive Summary

The VA Office of Accountability and Whistleblower Protection (OAWP) was established in 2017 to improve VA’s ability to hold employees accountable and enhance protections for whistleblowers.¹ This goal was to be accomplished, in part, by expanding VA’s ability to hold senior executives accountable for specified misconduct; preventing retaliation against whistleblowers and initiating action against supervisors who retaliate; and addressing senior executives’ poor performance.

A year later, in June 2018, the VA Office of Inspector General (OIG) received requests from Senators Tammy Baldwin, Richard Blumenthal, Sherrod Brown, Patty Murray, Jon Tester, and Representative Timothy Walz raising concerns that VA was not properly implementing the Department of Veterans Affairs Accountability and Whistleblower Protection Act (the Act). These requests came as a number of other complaints were being considered by the OIG regarding OAWP operations. In response, the OIG’s Office of Special Reviews conducted an initial review from June 2018 through December 2018. During the review, additional allegations arose, prompting further work through August 2019.²

The OIG’s review focused on answering the following questions that emerged from these complaints and allegations:

1. Whether the OAWP was exercising its authority in accordance with the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 and other applicable laws
2. Whether the OAWP conducted adequate, thorough, and procedurally fair investigations of matters it investigated
3. Whether VA employees were held accountable by making appropriate use of the authorities provided in the Act

¹ See Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, P.L. 115-41, 131 Stat. 862 (June 23, 2017). The legislation codified the establishment of the OAWP following an executive order issued in April 2017 to create an entity to “improve accountability and whistleblower protection” at VA. Improving Accountability and Whistleblower Protection at the Department of Veterans Affairs, Exec. Order No. 13793, 82 Fed. Reg. 20539 (Apr. 27, 2017). See also Dep’t of Veterans Affairs, News Release, “Secretary David Shulkin Announces Establishment of Office of Accountability and Whistleblower Protection and Names Peter O’Rourke as its Senior Advisor and Executive Director” (May 12, 2017).

² From June 23, 2017, until January 7, 2019, the OAWP operated without an assistant secretary—a position called for by the Act. It was led by Executive Director Peter O’Rourke from June 23, 2017, to February 28, 2018, followed by Executive Director Kirk Nicholas until January 7, 2019. The current Assistant Secretary for Accountability and Whistleblower Protection took office on January 7, 2019, and soon began implementing changes, some of which address matters identified throughout the review.

4. Whether the OAWP was adequately protecting whistleblowers from retaliation as required by the Act and other applicable laws
5. Whether VA complied with other requirements of the Act, including making timely and accurate reports to Congress.

The OIG identified significant deficiencies with respect to each of these questions. Notably, in its first two years of operation, the OAWP acted in ways that were inconsistent with its statutory authority while it simultaneously floundered in its mission to protect whistleblowers. Even recognizing that organizing the operations of any new office is challenging, OAWP leaders made avoidable mistakes early in its development that created an office culture that was sometimes alienating to the very individuals it was meant to protect. Those leadership failures distracted the OAWP from its core mission and likely diminished the desired confidence of whistleblowers and other potential complainants in the operations of the office. A summary of key findings related to each of the review questions follows.

The OAWP Misinterpreted Its Statutory Mandate, Resulting in Failures to Act Within Its Investigative Authority

The OAWP misconstrued its statutory investigative mandate both by accepting matters that it should not have and declining matters the Act requires it to investigate. The OAWP also investigated individuals who were not included within the scope of the OAWP's authority under the Act. This included investigating one of its own directors for allegations relating to the director's earlier position at another VA office. At the same time, it was too narrowly interpreting the scope of *what* the office should investigate. The OAWP inappropriately excluded investigations of misconduct and poor performance of covered individuals if the person making the allegations did not meet the statutory definition of whistleblower.

In addition to misinterpreting its statutory investigative mandate, the OAWP also failed to refer matters for investigation to other more appropriate investigative entities. VA employees must, for example, refer to the OIG matters that may be serious violations of criminal law related to VA. The OAWP investigated criminal matters involving possible felonies that it was required to refer to the OIG. Allegations of discrimination similarly should have been referred to VA's designated equal employment opportunity (EEO) office, the Office of Resolution Management (ORM), unless they fell within the OAWP's authority to investigate. Although the law does not require that the OAWP refer such matters to the ORM, filing with the ORM is the only way for employees to preserve their EEO rights and it has more expertise to handle investigations of discrimination.

The OAWP Did Not Consistently Conduct Procedurally Sound, Accurate, Thorough, and Unbiased Investigations and Related Activities

Written policies and procedures are crucial to effective operations. During the tenures of Executive Directors O'Rourke and Nicholas, the OAWP did not adopt comprehensive written policies and procedures on any topic. As of July 2019, it still lacked OAWP-specific written policies and procedures.³ The office also did not have a quality assurance process for identifying and preventing errors in its work.

The lack of clear written guidance for OAWP personnel contributed to the failure to consistently conduct investigations that were procedurally sound, accurate, thorough, and unbiased. Moreover, the OAWP Investigations Division was primarily staffed with human resources specialists whose position descriptions did not require extensive investigative training or experience. This deficiency was aggravated by the OAWP's failure to provide sufficient training on such critical topics as interviewing witnesses, conducting investigations, and writing reports.

A further investigative deficiency was the OAWP's practice of investigating to the "substantial evidence" standard. That is, OAWP investigators did not conduct investigations designed to ensure that all known or obviously relevant evidence was obtained.⁴ Rather, in many instances, they focused only on finding evidence sufficient to substantiate the allegations without attempting to find potentially exculpatory or contradictory evidence. One disciplinary official described OAWP investigations as "a [disciplinary] action in search of evidence."

VA Has Struggled with Implementing the Act's Enhanced Authority to Hold Covered Executives Accountable

A critical purpose of the Act was to facilitate holding Covered Executives accountable for misconduct and poor performance.⁵ However, as of May 22, 2019, VA had removed only one Covered Executive from federal service pursuant to the authority provided by the Act. The OIG found that officials tasked with proposing and deciding disciplinary action had insufficient direction for how to determine the appropriate level of discipline that would ensure consistency and fairness for specific acts of misconduct and poor performance. In many cases, a disciplinary official mitigated the discipline recommended by OAWP as too severe or based on advice from

³ OAWP staff reported during the review that written policies and procedures were being drafted.

⁴ For example, the Council of Inspectors General on Integrity and Efficiency, Quality Standards for Investigations (November 15, 2011) provide that all known or obviously relevant evidence should be obtained during an investigation. While OAWP is not governed by these standards, they provide relevant guidance for conducting thorough and objective investigations in a similar context.

⁵ "Covered Executives" in this report refer to VA personnel holding statutorily enumerated senior-level positions as defined in 38 U.S.C. §§ 323(c)(1)(H)(i) and (ii).

the VA's Office of General Counsel. In part, this was because of the absence of clear guidance and the OAWP's practice of not always including relevant exculpatory evidence.⁶

The OAWP Failed to Fully Protect Whistleblowers from Retaliation

From June 2017 to May 2018, the OAWP referred 2,526 submissions to other VA program offices, facilities, or other components that were not all equipped to undertake such investigations and without adequate measures to track the referrals or safeguards to protect whistleblowers' identities.⁷ Of these, at least 51 involved allegations of whistleblower retaliation by a supervisor (and so properly within the investigative authority of the OAWP). Complainants were not always advised of these referrals. Without guidance, OAWP personnel did not take sufficient steps to protect complainants' identities and prevent their concerns from being sent to the very facilities or network offices where the complainant worked or that were the subject of the allegations.

The OAWP also failed to establish safeguards sufficient to protect whistleblowers from becoming the subject of retaliatory investigations. One troubling instance involved the OAWP initiating an investigation that could itself be considered retaliatory. At the request of a senior leader who had social ties to the OAWP Executive Director, the OAWP investigated a whistleblower who had a complaint pending against the senior leader. After a truncated investigation, the OAWP substantiated the allegations without even interviewing the whistleblower.

In addition, former OAWP leaders made comments and took actions that reflected a lack of respect for individuals they deemed "career" whistleblowers. Moreover, at a time when the office was failing to meet its statutory requirements and purposes, then Executive Director Nicholas directed about 15 percent of the OAWP's FY 2018 budget to be obligated for contracts beyond its core mission.

VA Did Not Comply with Additional Requirements of the Act and Other Authorities

VA did not meet many other requirements of the Act and other authorities. Significant among these shortcomings were the following failures:

- To revise supervisors' performance plans and provide required training
- To implement whistleblower protection training for all employees

⁶ Under a pilot initiative implemented by Dr. Bonzanto in March 2019, VA's Office of General Counsel attorneys are now routinely provided access to the entire investigative file.

⁷ In April and May 2019, Dr. Bonzanto directed, as part of an effort to review all 539 investigations of whistleblower retaliation allegations received from June 23, 2017, through April 15, 2019, to determine if they were properly developed. A plan has been submitted for reviewing 42 disclosures determined to need further review.

- To meet its statutory obligation to submit responsive congressionally mandated reports
- To file systems of records notices
- To disclose routine uses of information

A worthy objective of the OAWP is to promote an environment in which whistleblowers feel comfortable in making complaints without fear of retaliation or reprisal. The former leaders of OAWP engaged in misdeeds and missteps that appeared unsupportive of whistleblowers while also failing to meet many of the other important objectives of the Act. Given the magnitude of the situation inherited by new OAWP leaders in January 2019, significant enhancements are needed for OAWP to meet its mission and purpose.

The OIG made 22 recommendations to improve VA processes that increase employee accountability and whistleblower protection.



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Contents

Abbreviations	vii
Introduction.....	1
Findings and Analysis.....	7
Finding 1: The OAWP Misinterpreted Its Statutory Mandate, Resulting in Failures to Act Within Its Investigative Authority.....	7
Finding 2: The OAWP Did Not Consistently Conduct Procedurally Sound, Accurate, Thorough, and Unbiased Investigations and Related Activities	21
Finding 3: VA Has Struggled with Implementing the Act’s Enhanced Authority to Hold Covered Executives Accountable	37
Finding 4: The OAWP Failed to Fully Protect Whistleblowers from Retaliation	45
Finding 5: VA Did Not Comply with Additional Requirements of the Act, Including Timely and Accurate Congressional Reporting.....	57
Finding 6: The OAWP Lacked Transparency in Its Information Management Practices..	65
Conclusion	71
Recommendations 1–22.....	71
Management Comments.....	73
OIG Response	74
Concerns with VA Action Plans	75
Appendix A: Scope and Methodology.....	77
Appendix B: Management Comments.....	79
OIG Contact and Staff Acknowledgments	90
Report Distribution	91

Abbreviations

A&A	Advisory & Analysis (Division)
HR&A	Human Resources and Administration
HVAC	U.S. House of Representatives Committee on Veterans' Affairs
OAR	Office of Accountability Review
OAWP	Office of Accountability and Whistleblower Protection
OGC	Office of General Counsel
OIG	Office of Inspector General
OMI	Office of the Medical Inspector
SVAC	U.S. Senate Committee on Veterans' Affairs
VISN	Veterans Integrated Service Network



Introduction

On May 12, 2017, then VA Secretary David Shulkin announced the establishment of the VA Office of Accountability and Whistleblower Protection (OAWP). Created by executive order, the OAWP was intended to improve VA’s efforts to hold its “employees accountable for their actions if they violate the public trust, and at the same time protect whistleblowers from retaliation.”⁸ In June, Congress passed the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, which was signed into law on June 23, 2017. The Act “codified and expanded [the] OAWP, assigned it specific responsibilities, and implemented new authorities to hold senior leaders and employees accountable.”⁹

A year later, in June 2018, the VA Office of Inspector General (OIG) received requests from Senators Tammy Baldwin, Richard Blumenthal, Sherrod Brown, Patty Murray, Jon Tester, and Representative Timothy Walz for a review of how VA was implementing the Act in light of allegations they received that its authorities were being “used in an inconsistent and inappropriate manner.” The OIG had also been receiving complaints from current and former VA employees, veterans, and members of the public raising similar concerns, particularly about OAWP’s operations and leaders’ actions. Although allegations varied in their specifics, some common themes emerged that focused the scope of the OIG’s review on answering the following questions:

1. Whether the OAWP was exercising its authority in accordance with the Act and other applicable laws
2. Whether the OAWP conducted adequate, thorough, and procedurally fair investigations of matters it investigated
3. Whether VA employees were held accountable by making appropriate use of the authorities provided in the Act
4. Whether the OAWP was adequately protecting whistleblowers from retaliation as required by the Act and other applicable laws
5. Whether VA complied with other requirements of the Act, including making timely and accurate reports to Congress

During its review, the OIG also identified concerns relating to OAWP’s compliance with the Privacy Act of 1974 and the Freedom of Information Act.

⁸ VA Office of Public Affairs, Press Release: “Secretary David Shulkin Announces Establishment of Office of Accountability and Whistleblower Protection and Names Peter O’Rourke as its Senior Advisor and Executive Director,” news release, May 12, 2017, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2904>.

⁹ VA 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 for the Period June 30, 2017 – June 30, 2018*, June 30, 2018.

The OIG's primary review period began with the statutory establishment of the OAWP on June 23, 2017, and ended on December 31, 2018. Unless otherwise noted, the information and data presented in this report pertain to this period. Upon taking office in January 2019, the current Assistant Secretary for Accountability and Whistleblower Protection began to implement changes. To provide the most current information practicable, and address more recent complaints, the OIG conducted additional work through August 2019, including document review and interviews with the Assistant Secretary and other OAWP staff.¹⁰

Creation of the Office of Accountability and Whistleblower Protection

Before the OAWP was established, the Office of Accountability Review (OAR) was responsible for investigating allegations of senior executive misconduct. Established as part of the VA Office of General Counsel (OGC) in 2014 at the direction of former VA Chief of Staff Jose Riojas, the OAR had a mandate to "receive, review, investigate, and resolve allegations of misconduct and lack of oversight by senior leaders."¹¹

In April 2017, President Donald Trump issued an executive order directing that

the Secretary shall establish in the VA the Office of Accountability and Whistleblower Protection (Office), and shall appoint a Special Assistant, reporting directly to the Secretary, to serve as Executive Director of the Office. The VA shall provide funding and administrative support for the Office, consistent with applicable law and subject to the availability of appropriations.¹²

Executive Order 13793 did not prescribe a particular scope of authority for the OAWP and it did not provide the OAWP with any specific investigative or disciplinary authority.

When the Act was signed into law on June 23, 2017, it statutorily established the OAWP and defined its functions and scope. The Act defined the functions of the OAWP as follows:

(A) Advising the Secretary on all matters of the Department relating to accountability, including accountability of employees of the Department, retaliation against whistleblowers, and such matters as the Secretary considers similar and affect public trust in the Department.

¹⁰ The OIG received several allegations of improper hiring practices within the OAWP. Most of these allegations related to past practices. However, some personnel moves made between January and June 2019 were also the subject of complaints. A commonly received complaint was that competitive service vacancies were being filled on a basis other than merit. The investigation of individual complaints of prohibited personnel practices was not within the scope of this review, although deidentified information was transmitted to VA. Witnesses raising allegations of whistleblower retaliation or prohibited personnel practices were encouraged to file complaints with the Office of Special Counsel or submit the allegations to the OIG hotline for handling in accordance with its usual protocols.

¹¹ OAR disbanded after OAWP was created and its staff and pending cases were reassigned to OAWP.

¹² Exec. Order No. 13793 (Apr. 27, 2017).

(B) Issuing reports and providing recommendations related to the duties described in subparagraph (A).

(C) Receiving whistleblower disclosures.

(D) Referring whistleblower disclosures received under subparagraph (C) for investigation to the Office of the Medical Inspector, the Office of Inspector General, or other investigative entity, as appropriate, if the Assistant Secretary has 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.

(E) Receiving and referring disclosures from the Special Counsel for investigation to the Medical Inspector of the Department, the Inspector General of the Department, or such other person with investigatory authority, as the Assistant Secretary considers appropriate.

(F) Recording, tracking, reviewing, and confirming implementation of recommendations from audits and investigations carried out by the Inspector General of the Department, the Medical Inspector of the Department, the Special Counsel, and the Comptroller General of the United States, including the imposition of disciplinary actions and other corrective actions contained in such recommendations.

(G) Analyzing data from the Office and the Office of Inspector General telephone hotlines, other whistleblower disclosures, disaggregated by facility and area of health care if appropriate, and relevant audits and investigations to identify trends and issue reports to the Secretary based on analysis conducted under this subparagraph.

(H) Receiving, reviewing, and investigating allegations of misconduct, retaliation, or poor performance involving—

(i) an individual in a senior executive position (as defined in section 713(d) of this title) in the Department;

(ii) an individual employed in a confidential, policy-making, policy-determining, or policy-advocating position in the Department; or

(iii) a supervisory employee, if the allegation involves retaliation against an employee for making a whistleblower disclosure.

(I) Making such recommendations to the Secretary for disciplinary action as the Assistant Secretary considers appropriate after substantiating any allegation of misconduct or poor performance pursuant to an investigation carried out as described in subparagraph (F) or (H).

Structure, Staffing, and Authorities of the OAWP

The Act established an Assistant Secretary for Accountability and Whistleblower Protection who is appointed by the President, confirmed by the Senate, and reports directly to the VA Secretary.¹³ The Act mandated that the 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,”¹⁴ and that “the Secretary may only assign to the Assistant Secretary responsibilities relating to the functions of the Office.”¹⁵

From June 23, 2017, until January 7, 2019, the OAWP operated without an assistant secretary. It was instead led by an executive director—a role that was filled first by Mr. Peter O’Rourke and subsequently by Mr. Kirk Nicholas. Since January 7, 2019, the OAWP has been led by Dr. Tamara Bonzanto, DNP, the first Assistant Secretary of Veterans Affairs for Accountability and Whistleblower Protection.¹⁶

OAWP’s Structure and Staffing

The OAWP is organized into five divisions: Triage, Investigations, Advisory & Analysis, Knowledge Management, and Human Resources & Office Support. The functions of each division are summarized in Figure 1.

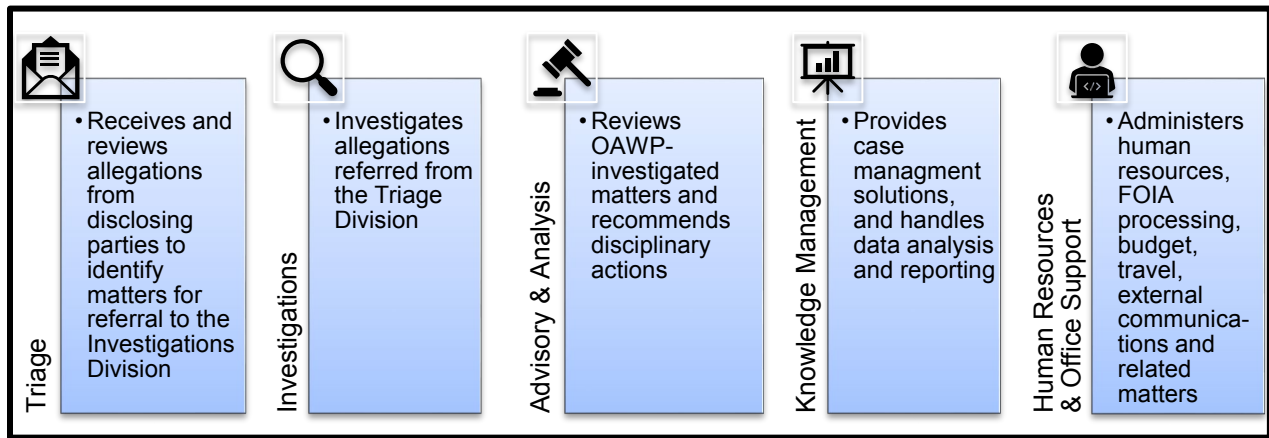


Figure 1. Organizational components of the Office of Accountability and Whistleblower Protection

Source: VA OIG Analysis

On June 12, 2017, then VA Secretary Shulkin reassigned OAR personnel to staff the OAWP. At that time, the OAR was composed of 52 staff (five executive leaders, six operations staff, five data analytics staff, 30 investigative staff, and six triage staff). By June 18, 2018, the OAWP

¹³ 38 U.S.C. § 323(b).

¹⁴ 38 U.S.C. § 323(e).

¹⁵ 38 U.S.C. § 323(b)(4).

¹⁶ DNP is an individual with a doctorate in nursing practice.

brought on additional employees to nearly double its personnel to 103 staff, distributed among its leadership and five divisions.

Table 1. OAWP Staffing Numbers as of June 18, 2018

Division	Count
Executive Leadership	9
Triage Division	26
Investigations Division	30
Advisory & Analysis Division	15
Human Resources and Office Support	14
Knowledge Management Division	9
Total	103

Source: OIG Analysis of organizational charts dated June 18, 2018, confirmed as current by the OAWP as of March 7, 2019

The primary organizational difference between the former OAR and the OAWP was the establishment of the Advisory & Analysis Division (A&A Division). Mr. O’Rourke explained to OIG investigators that the A&A Division was created to handle disciplinary decisions and related analysis to focus the Investigations Division’s efforts on fact-finding and not discipline. Since November 2017, the A&A Division has been led by the A&A Director, a lawyer whose experience included practicing employee relations law for the U.S. Department of Justice for more than four years (hereafter A&A Director).

OAWP’s Investigative Authority

The Act broadly authorized the OAWP to investigate the conduct of any VA supervisory employee “if the allegation involves retaliation against an employee for making a whistleblower disclosure.”¹⁷ In addition, the Act gave the OAWP a specific scope of authority to investigate “allegations of misconduct, retaliation, or poor performance” for certain senior executives.¹⁸ The Act did not authorize the OAWP to conduct investigations of any other class of employees or subject matters.

The OAWP receives submissions (typically complaints or allegations of wrongdoing) from many sources, including current, former, and prospective VA employees; veterans; elected officials; and members of the general public. All submissions are first reviewed by the Triage Division, and then routed in accordance with the Triage Division’s procedures.

¹⁷ 38 U.S.C. § 323(c) (1)(H)(iii).

¹⁸ 38 U.S.C. § 323(c) (1)(H) (defining scope of OAWP investigative authority).

Submissions determined to fall within OAWP's investigative authority are referred to the OAWP Investigations Division. For other submissions, the Act authorizes the OAWP to refer

whistleblower disclosures received [pursuant to the Act] for investigation to the Office of the Medical Inspector [OMI], the Office of Inspector General, or other investigative entity, as appropriate, if the Assistant Secretary has 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.¹⁹

To the extent that the OAWP receives allegations of potential felony criminal conduct, the OAWP must refer these to the OIG.²⁰ From June 23, 2017, to December 31, 2018, the OAWP referred 38 allegations to the OIG, eight allegations to VA's Office of Resolution Management (ORM), and 13 allegations to OMI.

OAWP's Authority to Recommend Disciplinary Action

Once a matter has been investigated, the results of the investigation are forwarded to the A&A Division for review. The A&A Division assesses the results of the investigation and determines whether disciplinary action is appropriate. If disciplinary action is deemed appropriate, a memorandum is provided to the VA Secretary indicating that the OAWP is recommending disciplinary action without further details. Unless the Secretary objects, the OAWP then engages with a proposing official and drafts a proposal containing the A&A Division's disciplinary recommendation in consultation with the VA Office of General Counsel.²¹

OAWP's authority is limited to making recommendations about discipline. The determination about whether to discipline an employee is made by officials within the employee's supervisory chain or as designated by the VA Secretary. When the A&A Division recommends a disciplinary action, it engages with VA Office of General Counsel attorneys and management officials who are senior to the employee who is the subject of the recommendation. The management officials include a "proposing official" and "deciding official." The proposing official is responsible for reviewing the evidence file and proposing the disciplinary action to be taken. The deciding official reviews the proposed disciplinary action and reply from the subject employee, and

¹⁹ 38 U.S.C. § 323(c)(1)(D).

²⁰ 38 CFR § 1.204. As discussed in Finding 1, VA employees are required to report potential criminal conduct to a supervisor or the OIG. Felonies must be referred to the OIG. Because of the potential challenge in parsing a felony versus a misdemeanor, the OIG encourages VA employees to refer all potential criminal conduct involving VA to its Office of Investigations or hotline.

²¹ The memorandum simply indicates the OAWP is recommending a disciplinary action against an employee; it does not indicate the specific disciplinary action recommended, nor does it describe the circumstances giving rise to the recommendation. See Figure 6 on page 61 for more information on the OAWP triage and subsequent processes.

determines whether to sustain, mitigate, or set aside the proposed disciplinary action. A Covered Executive may also file a grievance contesting the deciding official's determination to a grievance official, who makes a final decision.²²

Findings and Analysis

Finding 1: The OAWP Misinterpreted Its Statutory Mandate, Resulting in Failures to Act Within Its Investigative Authority

Under the Act, the functions of the OAWP include (1) receiving and referring whistleblower disclosures and (2) receiving, reviewing, and investigating defined categories of allegations involving specific VA employees. The OAWP, however, misconstrued its statutory mandate and investigative authority resulting in its staff investigating individuals outside the legislative scope, failing to refer matters to other investigative entities when appropriate, and simultaneously declining to investigate other matters that were within its scope.

²² Corporate Senior Executive Management Office Letter No. 006-17-1, *Senior Executive Accountability and Grievance Procedures*, July 7, 2017.

The OAWP’s Advertisement of Its Scope Reflected a Lack of Understanding

The OAWP held itself out on its public website for more than a year as having “a broad and expansive mission” and as committed to “unbiased investigation of all allegations and concerns” relating to VA employees.²³

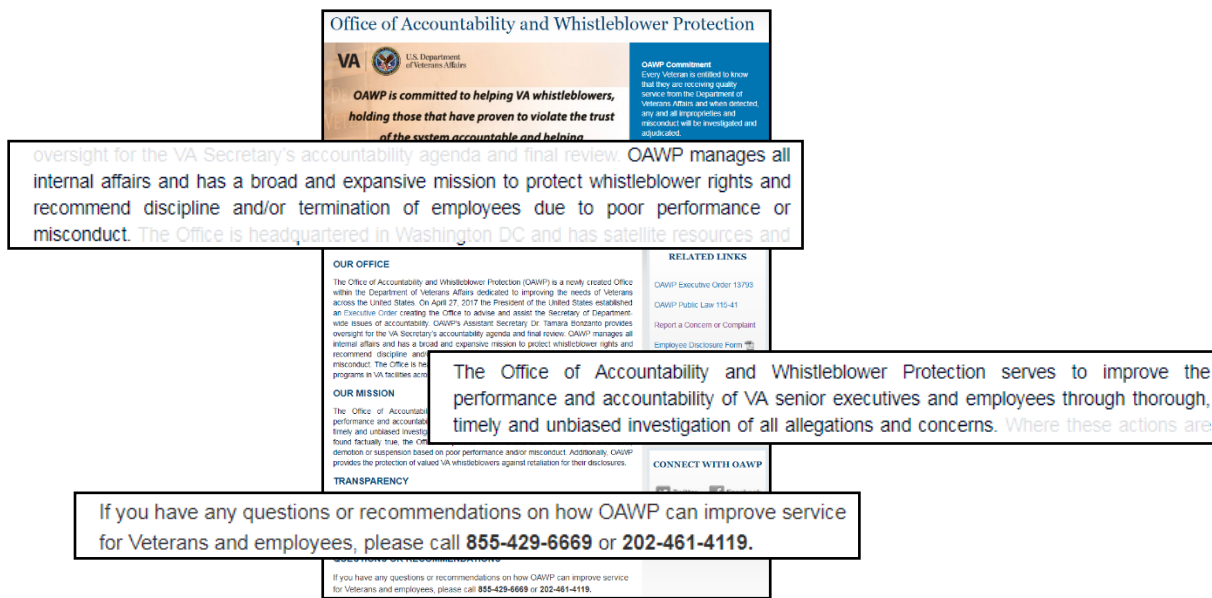


Figure 2. Excerpts from the OAWP website, describing its mission
 Source: *OIG analysis, website accessed on May 21, 2019*

Contrary to this description, however, the Act gives the OAWP a narrower scope of authority to investigate allegations against specific VA employees. Under the Act, the OAWP is authorized to investigate “allegations of misconduct, retaliation, or poor performance” as to three categories of employees.²⁴ First, it may investigate such allegations against a VA supervisory employee, but only “if the allegation involves retaliation against an employee for making a whistleblower disclosure.”²⁵ It may also investigate such allegations against individuals who fall into one of two additional categories:

- VA personnel holding statutorily enumerated senior-level positions (Covered Executives).²⁶ This includes career members of the Senior Executive Service

²³ This language appeared on the OAWP website from April 2018 until July 18, 2019.

²⁴ 38 U.S.C. § 323(c)(1)(H).

²⁵ 38 U.S.C. § 323(c)(1)(H)(iii).

²⁶ 38 U.S.C. §§ 323(c)(1)(H)(i) and 713(d)(3).

(SES).²⁷ It also applies to individuals in an “administrative or executive position” who are

(a) members of the Office of the Under Secretary for Health,²⁸ or (b) “physicians, dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries.”²⁹

- VA personnel “employed in a confidential, policy-making, policy-determining, or policy-advocating position” (VA Policy Makers).³⁰

From June 23, 2017, to December 31, 2018, the OAWP Triage Division received at least 3,694 submissions. Of these, only 547 were referred by the Triage Division to the Investigations Division (as discussed below, these submissions included allegations that the OIG determined exceeded the OAWP’s statutory mandate to investigate). The OAWP’s advertised mission of investigating “all allegations and concerns” was not consistent with its practices—which could have contributed to the frustration expressed by some complainants to the OIG hotline that OAWP was not fulfilling its stated objectives.

The OAWP Investigated Employees and Matters Beyond Its Authority

Some of the confusion OAWP staff expressed surrounding OAWP’s investigative authority can be attributed to a misplaced dependence on the former OAR duties and then a “delegation of authority” granted to OAWP’s executive director—neither of which aligned with the OAWP’s actual statutory authority. From June 23, 2017, until January 2019, the OAWP operated without an assistant secretary and was, instead, led by an executive director. Initially, the OAWP executive director relied on the authority delegated to the former OAR, which included authority to conduct investigations of certain senior officials. On February 7, 2018, the executive director was delegated authority to carry out various functions of the OAWP.³¹ The delegation included

²⁷ 5 U.S.C. § 3132(a)(4). Other members of the Senior Executive Service that are not included are noncareer appointees, limited-term appointees, and limited emergency appointees. See 5 U.S.C. § 3132(a)(4) – (7).

²⁸ 38 U.S.C. § 7306(a).

²⁹ 38 U.S.C. § 7401(1).

³⁰ 38 U.S.C. § 323(c)(1)(H)(ii). Although the OAWP has not defined which positions fall within the VA Policy Makers classification, it has included political appointees in its scope.

³¹ VA Memo No. VAIQ 7819162, Delegation of Authority—Executive Director of the Office of Accountability and Whistleblower Protection, February 7, 2018.

the authority to “receive, review, and as necessary, investigate allegations of misconduct related to accountability and whistleblower issues” for the following seven categories of personnel:

- (1) All positions centralized to the Secretary of Veterans Affairs;
- (2) Members of the Senior Executive Service;
- (3) Employees who occupy an administrative or executive position and who are appointed under 38 U.S.C. §§ 7306, 7401(1), or 7401(4);
- (4) Associate and Assistant Directors in the Veterans Health Administration;
- (5) Cemetery Directors in the National Cemetery Administration;
- (6) Individuals employed in a confidential, policy-making, policy-determining, or policy-advocating position in the Department;³² and
- (7) General Schedule (GS)-15 Program Office and Regional Office heads within VA Central Office and reporting directly to VA Central Office, including staff offices.

An OAWP Senior Advisor (hereafter the Senior Advisor), at the direction of then Executive Director O’Rourke, drafted the delegation. It appears from email records that the categories of personnel identified in the delegation were based, in part, on incorporating into the delegation the investigative scope of the defunct OAR, even though its authority differed from OAWP’s statutory authority. The OAWP does not have authority to investigate individuals in all seven categories if the allegation is not whistleblower retaliation.³³ Specifically, not all positions centralized to the Secretary, cemetery directors, and GS-15 program and regional office heads are Covered Executives or VA Policy Makers under OAWP’s legislative authority.³⁴

Although the VA Secretary generally has broad latitude to delegate to subordinate officials to carry out VA’s duties,³⁵ Congress limited the VA Secretary’s ability to delegate to the OAWP in the Act. The Act provides that “the Secretary may only assign to the Assistant Secretary responsibilities relating to the functions of the Office set forth in [the Act].”³⁶ Accordingly, the

³² Mr. O’Rourke told the OIG that the OAWP had not determined how to interpret “Individuals employed in a confidential, policy-making, policy-determining, or policy-advocating position in the Department.”

³³ 38 U.S.C. § 323(c)(1)(H).

³⁴ Only the SES-level employees would be subject to the OAWP’s authority to investigate misconduct and poor performance unless the allegation included whistleblower retaliation. See 38 U.S.C. § 323(c)(1)(H)(iii). With respect to cemetery directors, OAWP officials were aware that position-level grades range from GS-11 to SES, and that SES positions are “few and far between.”

³⁵ 38 U.S.C. § 308(b).

³⁶ 38 U.S.C. § 323(b)(4).

Secretary did not have the authority to expand OAWP's investigative scope by delegating authority to investigate categories of individuals other than those identified in the Act.³⁷

The VA Office of General Counsel (OGC) reviewed and approved a prior version of the delegation. Although it was revised slightly before it was signed by the former VA Secretary, the revisions did not change the OGC-approved categories of individuals covered by the delegation, which included individuals outside the scope of OAWP's investigative authority. In February 2018, soon after the delegation was signed and distributed, OGC attorneys raised concerns about the scope of the delegation.³⁸ On April 24, 2018, then General Counsel James Byrne provided Mr. Nicholas with a draft revision to the delegation, which aligned with the Act's description of the OAWP's investigative scope. Between April and November 2018, OGC attorneys had multiple communications with OAWP leaders regarding the delegation. OGC attorneys had understood that the OAWP had committed to changing the delegation to a version the OGC had approved that aligned with the Act. Additional emails reflect that the OGC continued raising this issue with Mr. Nicholas as late as November 2018, but that the delegation remained in effect.³⁹ Emails among OAWP leaders indicate that from at least June 2018 to March 2019, the OAWP was continuing to seek a delegation that was materially different from OGC's recommendation and included individuals in the investigative scope who were not within OAWP's authority under the Act.

The OAWP Investigated Employees Not Within Its Statutory Scope

The OIG found that the OAWP investigated individuals who were outside of its statutory scope. In some instances, these individuals were within the scope of the February 2018 delegation; however, in others, the individuals were outside the scope of both OAWP's statutory and delegated authority. Instead of investigating these allegations, the OAWP should have declined or referred all such matters for investigation to another VA component or outside entity.

In its June 2018 annual report to Congress, the OAWP acknowledged limitations on its scope and requested congressional consideration of an expansion.

³⁷ The delegation at issue was to the executive director, not an assistant secretary. However, that distinction does not appear relevant to whether the scope of the OAWP's investigative authority under the Act could be expanded by a delegation from the VA Secretary. See 38 U.S.C. § 323(b)(4). The functions of the office are clearly defined in the statute and an expansion of the function of the office via a delegation to the executive director, even if not directly prohibited by the Act, appears contrary to Congress's intent.

³⁸ Two days after the delegation was signed, the then Executive Secretary to VA sent an email stating that the delegation "is rescinded" and that a "revised version will be issued upon approval." No memo of rescission nor a revised version of the delegation was ever issued. An OGC attorney told OIG investigators that it was unclear whether the delegation was, in fact, rescinded. The OAWP continued to operate as if the delegation were in effect.

³⁹ The delegation appears to be of little current effect given that an assistant secretary has been confirmed and there is no longer an executive director of OAWP. Nonetheless, to the extent that the delegation is being used by the OAWP to shape its scope, rescission would be appropriate to avoid perpetuating confusion.

The current language in 38 U.S.C. section 323(c)(1)(H) describes a specific sub-set of individuals to be investigated by OAWP. While the listed individuals represent some senior leaders in the VA, a broader definition is needed to ensure all supervisors and managers responsible for leading major VA activities are consistently held to the same standard of accountability. For example, a typical VA medical center is led by a group of five employees (Medical Center Director; Chief of Staff; Nurse Executive; Assistant Director, and Associate Director). As currently written only three (Medical Center Director, Chief of Staff and Nurse Executive) of the five are within the scope of OAWP's statutory charter. Additionally, the senior leadership of other major VA facilities fall outside the current statutory coverage such as Cemetery Directors and General Schedule office directors of VBA Regional Offices.⁴⁰

At the time of OAWP's report to Congress, the OAWP was operating under a delegation that purported to grant it authority to investigate some of these categories of individuals, which it conceded were outside the scope of its authority. The OIG identified a number of instances in which OAWP investigated individuals outside its authority, both before and after its June 2018 report to Congress.

Example 1

In June 2018, the OAWP investigated allegations that a police officer, a GS-6, used excessive force against a patient. The allegation was investigated at the request of former Executive Director Nicholas "due to [VA Secretary] awareness." The OAWP did not substantiate the allegations.

The allegation in Example 1 involved a GS-6 employee who is not within OAWP's statutory scope (where there is no allegation of whistleblower retaliation by a supervisor). This was similarly outside the scope of the February 2018 delegation, and the potentially serious criminal nature of the violation necessitated a referral to the OIG by the OAWP.⁴¹ The OIG's records reflect reports about this incident from multiple other sources, but do not indicate any OAWP referrals.

Example 2

In September 2018, a VHA employee relations specialist sought information relating to OAWP's scope. The Triage Division advised that the OAWP

⁴⁰ VA Office of Accountability and Whistleblower Protection, *VA 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*. This requested expansion is not the subject of any pending legislation at this writing.

⁴¹ 38 CFR § 1.204.

“currently does have jurisdiction over all GS-15 employees.” This is an improper statement of OAWP’s authority under the Act as well as the February 2018 delegation, which included only those “General Schedule (GS)-15 Program Office and Regional Office heads within VA Central Office and reporting directly to VA Central Office.” As a result of the Triage Division’s incorrect advice, a submission was made to the OAWP relating to allegations of misconduct by a GS-15 public affairs specialist. The Triage Division referred the matter to the Investigations Division. The OAWP determined there was no basis for a formal disciplinary action. However, changes were made to the public affairs specialist’s performance standards and a “performance expectation” memorandum was prepared to reflect such changes.

The OAWP did not have statutory authority to investigate the allegations in Example 2 because a GS-15 employee is not within the category of individuals the OAWP may investigate unless the allegation was whistleblower retaliation. This employee was also not covered by the February 2018 delegation because that was limited to only certain GS-15 employees. The public affairs specialist was not a program office or regional office head within, and reporting directly to, VA Central Office.

Example 3

In September 2018, the OAWP received a submission alleging gross mismanagement, including contracting issues, related to capital improvement projects at a VA medical center. The allegations involved three individuals: a division chief (GS-14), a capital asset manager (GS-14), and a contracting director (GS-15). In May 2019, the Triage Division referred the matter to the OIG, and the OIG declined because the allegations primarily related to personnel matters. Following the declination, the Triage Division referred the matter to the OAWP Investigations Division where it remains.

Example 3 was not within OAWP’s statutory authority to investigate because it does not have authority to investigate allegations of misconduct or poor performance involving GS-14 and GS-15 employees. These individuals also were not within the scope of the delegation, which included some, but not all, GS-15 employees. Following the OIG’s declination, the matter should have been referred to another VA component for review, such as the Office of Acquisition, Logistics, and Construction for major construction or the VISN in which the allegations arose for minor construction.

Example 4

Also in September 2018, the OAWP received a submission with multiple allegations concerning a GS-13 cemetery director. The OAWP elected to

investigate the portion of the allegations pertaining to the cemetery director's misuse of government time and resources. The remainder of the allegations, including that the cemetery director was disrespectful to the staff, were referred to the National Cemetery Administration leaders. This matter remained pending as of the end of May 2019.

Although the February 2018 delegation included cemetery directors in the scope of the investigative authority delegated to the OAWP, this was inconsistent with the Act. In Example 4, the GS-13 cemetery director was not a Covered Executive or a VA Policy Maker and the allegations the OAWP investigated did not relate to whistleblower retaliation. As a result, the investigation exceeded OAWP's statutory mandate. The VA Office of Resolution Management had also received the allegations and was prepared to investigate if the OAWP declined.

The OAWP Investigated Its Own Division Director in a Matter Outside Its Scope

OIG investigators received allegations and information from multiple sources within the OAWP alleging that OAWP staff had investigated one of its own directors but failed to hold this individual accountable for misconduct. The OIG partially substantiated the allegations, finding that the OAWP did investigate one of its directors and she/he had engaged in misconduct when this individual worked at another component of VA. As of July 2019, no disciplinary action had been taken against the director, who remains employed by VA. The OIG, however, identified no evidence that OAWP officials purposefully attempted to influence the investigation or the still-pending disciplinary process.

This investigation was not within OAWP's scope because it did not involve a Covered Executive or VA Policy Maker, nor did the allegations include a claim of whistleblower retaliation. The alleged misconduct related to when the subject employee was a Veterans Health Administration (VHA) employee prior to joining the OAWP. Emails reflect that OAWP staff considered referring this matter for investigation to the VHA component in which the alleged misconduct occurred. According to an email exchange, the OAWP retained the investigation, in part, because the VHA component "might feel intimidated by having to interview a now-OAWP employee." To mitigate the appearance of bias, an OAWP official assigned the matter to an investigator who did not know the OAWP leader in question "well."

Case notes reflect that the investigator submitted the investigation report on January 7, 2019, substantiating the misconduct allegations. An OAWP official told the OIG that after receiving the results of the investigation, the OAWP official directed another senior OAWP official to take another look to "make sure" because it was "a pretty serious matter." In late March 2019, multiple OAWP officials (excluding the director who was the subject of the investigation)

reviewed the results of the investigation, which resulted in referring the case file to OGC for advice.

In July 2019, the OIG learned that the matter remained unresolved and that current OAWP leaders are evaluating whether it is necessary to refer the matter to another investigative entity for independent investigation. Immediate referral to another investigative entity would have been appropriate both to adhere to its statutory scope and to avoid the appearance of bias or impropriety that can undermine confidence in an office trying to establish trust among VA employees.

The OAWP Investigated Subject Matters That It Should Have Referred

The Act requires the OAWP to refer a whistleblower disclosure

for investigation to the Office of the Medical Inspector, the Office of Inspector General, or other investigative entity, as appropriate, if the Assistant Secretary has reason to believe [a] whistleblower disclosure [received by the OAWP] 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.⁴²

Unless such a disclosure falls within the OAWP's statutory authority to investigate, it should be referred to another investigative entity, as appropriate. When the matter involves a felony, it must be referred to the OIG, and good practice would be to refer any possible crime to the OIG for consideration.

Some Allegations of Potential Crimes Not Referred to the OIG

The OAWP investigated allegations of potential criminal matters that should have been referred to the OIG for consideration. VA regulations require VA employees to report potential criminal acts to a supervisor or to the OIG.⁴³ However, where the potential criminal act involves a felony, VA employees must *refer* the matter to the OIG.⁴⁴ The distinction between a crime that is classified as a felony and one that is classified as a misdemeanor is based on the seriousness of the offense and the length of the associated prison sentence.⁴⁵ In some cases, determining whether an alleged crime involves a felony may not be possible until after an investigation. As such, it may be difficult for VA employees to determine which potential crimes involve felonies

⁴² 38 U.S.C. § 323(c)(1)(D).

⁴³ 38 CFR § 1.201.

⁴⁴ 38 CFR § 1.204.

⁴⁵ Under federal law, a felony is an "offense punishable by a maximum term of imprisonment of more than one year." 18 U.S.C. § 3156.

that must be referred to the OIG and which involve misdemeanors that need only be reported to a supervisor. Given that difficulty, the best practice for any VA employee is to refer *any* possible criminal acts to the OIG for potential investigation.⁴⁶

Examples 5 and 6 summarize two allegations involving potential criminal conduct that the OAWP should have referred to the OIG or, at the very least, have coordinated with the OIG prior to initiating an investigation.⁴⁷

Example 5

*In April 2018, the OAWP received allegations that a Covered Executive was engaging in contracting abuse, conflicts of interest, and violations of federal ethics rules. Some of these matters included alleged abuses of authority and/or potential felony criminal violations. These allegations were bundled with several others that included whistleblower retaliation and issues within OAWP's scope. The OIG could locate no records in OAWP's or OIG's databases indicating that the contracting abuse, conflict of interest, and ethics allegations had been referred to the OIG despite possibly involving felony violations of federal laws on receiving gifts, making false statements, or other related crimes.*⁴⁸

In Example 5, the allegations the OAWP investigated included potential criminal violations (such as an employee's improper financial gain) that should have been referred to the OIG as required by regulation.⁴⁹ In this case, some of the allegations of potential criminal activity appear to have been sparked by the complainant's review of an OIG audit report, which analyzed the administration of a VA program but did not address individual wrongdoing.⁵⁰ Although there may have been some overlap between the scope of the OIG's audit and the allegations the OAWP investigated, there were sufficient differences in the allegations the OAWP received that

⁴⁶ As a practical matter, any serious allegations of waste, fraud, and abuse that affect VA programs, operations, or put veterans at risk for harm or financial loss should be reported to the OIG to determine if its resources and expertise should be employed, particularly those matters that are due to more than a single individual's error or action.

⁴⁷ The OIG review team referred these allegations, identified during its OAWP review, to the OIG hotline for processing.

⁴⁸ The OAWP initially substantiated that the Covered Executive's spouse received \$520 worth of tickets to accompany the Covered Executive to a sporting event acting in an official capacity. It was later determined that the spouse had not received a gift after all.

⁴⁹ It is a felony to receive compensation for or have a financial interest in a federal government contract in which you are involved as a federal employee. See 18 U.S.C. §§ 203 and 208.

⁵⁰ Because the complainant was not a VA employee (or individual seeking VA employment), the complaint in Example 5 did not meet the statutory definition of a whistleblower disclosure under the Act. Nevertheless, the OAWP should have referred the matter to the OIG because of the potential felony violations as required by regulation (38 CFR § 1.204).

staff should have referred them to the OIG prior to conducting their own investigation.⁵¹ The OAWP should not have assumed that the OIG had no further interest in the allegations simply because there was a somewhat-related audit report.

Example 6

In January 2018, the OAWP received multiple allegations related to a GS-15 employee. The allegations included that the employee was attempting to steer the award of a contract to a personal friend's employer. OAWP's documentation is insufficient to determine whether its personnel reviewed the contract steering allegation as part of its investigation. As of May 2019, OAWP's investigation remained open.

In Example 6, the allegation of steering a contract suggests a potential felony that should have been referred to the OIG under the Act and as required by regulation.⁵²

Inadequate Procedures and Role Clarification for Allegations of Discrimination

The Senior Advisor indicated that allegations of a hostile work environment, which is a complaint predicated upon discriminatory workplace harassment, is one of OAWP's most commonly received complaints. It is a violation of law for an employer to discriminate on the basis of an employee's statutorily protected status.⁵³ To the extent that such allegations otherwise satisfy the Act's definition of a whistleblower disclosure and are not within OAWP's investigative authority, the Act requires the OAWP to refer such allegations to an "other investigative entity, as appropriate." It would be appropriate to refer allegations of discrimination to VA's Office of Resolution Management. ORM is responsible for providing equal employment opportunity (EEO) complaint processing services within VA, which includes conducting investigations pursuant to complaints of discrimination. Filing with the ORM is the only way for employees to preserve their EEO rights.⁵⁴ In addition, participating in the ORM's EEO process is

⁵¹ Among other considerations, the OAWP should have confirmed that the OIG did not have an open criminal investigation stemming from the audit.

⁵² 18 U.S.C. § 205. It is a crime to act as agent for another party in a matter in which the United States has an interest, including a federal contract. This is a good example of why it is difficult for OAWP or other VA components to determine whether an alleged criminal act is potentially a felony that must be referred to the OIG. A "willful" violation of the statute may be punished by up to five years in prison, and is thus considered a felony, whereas a violation that is not "willful" is subject to no more than one year imprisonment. 5 U.S.C. § 216(a) (setting forth the penalties for a violation of 18 U.S.C. § 205).

⁵³ See, e.g. 42 U.S.C. § 2000e-2 (prohibiting discrimination on the basis of race, color, religion, sex, or national origin). There are other statutorily protected classes.

⁵⁴ An aggrieved VA employee must begin the process with ORM within 45 calendar days of the date the alleged discrimination occurred, otherwise the right to pursue an EEO complaint may be lost. See the VA Office of Diversity and Inclusion's "Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement," July 5, 2017, rev. August 27, 2018 (EEO Policy Statement).

generally the only way that an aggrieved employee may be made whole through enforceable adjudication if a supervisor is found to have discriminated.⁵⁵

It is not uncommon for an allegation of discrimination to coincide with allegations of other misconduct or poor performance that may be within the OAWP's statutory authority to investigate. In such circumstances, the OAWP needs a process to ensure that its review of the remaining allegations can proceed in a coordinated manner with the work of the ORM. In addition, the OAWP must communicate clearly about its investigative scope so that individuals submitting allegations of discrimination understand that the appropriate avenue for redress of EEO matters is with the ORM. The OIG determined that the Triage Division's procedures did not fully address the need to ensure that disclosing parties are advised that discrimination allegations should be raised with the ORM, and fully documenting OAWP's advisement in each case.

The OAWP Declined Matters Within Its Statutory Mandate by Misconstruing Its Investigative Authority

Matters that fall within OAWP's statutory authority likely were overlooked because OAWP's triage procedures excluded complaints that did not qualify as whistleblower disclosures under the Act. The OAWP staff appear to have conflated its authority *to investigate* with its duty *to receive and refer whistleblower disclosures*.⁵⁶ The written standard operating procedures adopted by the Triage Division (the triage SOPs) limit investigations by the OAWP to submissions that meet the definition of a whistleblower disclosure under the Act.⁵⁷ This restriction does not appear to have any basis in the Act.⁵⁸ It is also inconsistent with the procedures issued by the VA Secretary in July 2017 (2017 accountability procedures), stating, "OAWP or, as specifically delegated by OAWP, an Organization, *shall* review and, if necessary, investigate *any* allegation or other evidence of Misconduct, poor performance, or Retaliation, using appropriate processes" (emphasis added).⁵⁹

www.diversity.va.gov/policy/statement.aspx. Allegations raised to avenues outside ORM—including the OAWP—do not constitute initiation of an EEO complaint and do not extend the 45-calendar day time limit.

⁵⁵ VA Directive 5977, *Equal Employment Opportunity Discrimination Complaints Process*, May 5, 2011; 38 U.S.C. § 516(b) and the VA Office of Diversity and Inclusion's EEO Policy Statement.

⁵⁶ 38 U.S.C. §§ 323(c)(1)(C) and 323(c)(1)(D).

⁵⁷ The OAWP appears to continue to misconstrue the statute. The OAWP's current website states that it "directly investigates *whistleblower* disclosures that raise allegations of misconduct, retaliation, or poor performance involving—" Covered Executives, VA Policy Makers, and supervisory employees if it is an allegation of whistleblower retaliation. (emphasis added)

⁵⁸ 38 U.S.C. § 323(c)(1)(H).

⁵⁹ VA Letter No. 006-17-1, *Senior Exec. Accountability and Grievance Procedures*, July 7, 2017. The July 2017 accountability procedures only apply to Covered Executives. The procedures do not apply to political appointees or

The OAWP has the authority to investigate *all allegations of misconduct and poor performance* involving Covered Executives or VA Policy Makers.⁶⁰ This would include allegations that do not qualify as whistleblower disclosures. The Act defines a whistleblower disclosure as

any disclosure of information by an employee of the Department or individual applying to become an employee of the Department which the employee or individual reasonably believes evidences—(A) a violation of a law, rule, or regulation; or (B) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.⁶¹

Consequently, an allegation made by a non-employee or non-applicant (such as a former employee, member of Congress, veteran, family or community member) does not qualify as a whistleblower disclosure under the Act.

Moreover, an allegation that involves employee misconduct as defined in the statute—such as neglect of duty—may not be considered a whistleblower disclosure under the Act because it does not evidence a violation of law, rule or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific danger to public health or safety.⁶²

OAWP’s overly restrictive interpretation of its investigative authority could have resulted in allegations that fall within OAWP’s scope being closed without further examination. One individual interviewed by the OIG said that he identified at least one instance in which an allegation against a Covered Executive or VA Policy Maker was closed by the Triage Division without an investigation because it did not rise to the level of a whistleblower disclosure. Notwithstanding what is in the triage SOPs, the former director of the Triage Division and the current OAWP Acting Deputy Executive Director reported that, in practice, the Triage Division did refer allegations involving “senior leaders” that did not qualify as whistleblower disclosures to the OAWP Investigations Division.⁶³

Witnesses provided the OIG with conflicting responses when explaining whether the OAWP curtailed its investigative authority to investigate only matters that arose from whistleblower complaints. Similarly, the OIG’s review of cases identified examples in which the source of the allegation was not a whistleblower. The conflicting information on this subject underscores the

supervisory employees, if the allegation is whistleblower retaliation, which the OAWP also has authority to investigate.

⁶⁰ 38 U.S.C. § 323(c)(1)(H).

⁶¹ 38 U.S.C. § 323(g)(3).

⁶² Misconduct is defined in 38 U.S.C. § 713 as “neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of function.”

⁶³ The Triage SOPs’ definition of “senior leaders” mirrors the definition in the February 7, 2018, Delegation of Authority, which improperly expands the OAWP’s scope to include categories of personnel not identified in the statute.

need for the OAWP to issue clear written triage guidance that conforms with the OAWP's statutory scope.

Finding 1 Conclusion

The OIG determined that the OAWP investigated matters outside its scope; failed to refer certain matters, as appropriate, to other investigative entities; and misconstrued its investigative authority in ways that excluded matters actually within its scope.

Recommendations 1–4

1. The Assistant Secretary for Accountability and Whistleblower Protection directs a review of the Office of Accountability and Whistleblower Protection's compliance with the VA Accountability and Whistleblower Protection Act of 2017 requirements in order to ensure proper implementation and eliminate any activities not within its authorized scope.
2. The VA Secretary rescinds the February 2018 Delegation of Authority and consults with the Assistant Secretary for Accountability and Whistleblower Protection, the VA Office of General Counsel, and other appropriate parties to determine whether a revised delegation is necessary, and if so, ensures compliance with statutory requirements.
3. The Assistant Secretary for Accountability and Whistleblower Protection, in consultation with the Office of General Counsel, Office of Inspector General, Office of the Medical Inspector, and the Office of Resolution Management establishes comprehensive processes for evaluating and documenting whether allegations, in whole or in part, should be handled within the Office of Accountability and Whistleblower Protection or referred to other VA entities for potential action or referred to independent offices such as the Office of Inspector General.
4. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that policies and processes are developed, in consultation with the VA Office of General Counsel and Office of Resolution Management, to consistently and promptly advise complainants of their right to bring allegations of discrimination through the Equal Employment Opportunity process.

Finding 2: The OAWP Did Not Consistently Conduct Procedurally Sound, Accurate, Thorough, and Unbiased Investigations and Related Activities

The OIG recognizes it takes tremendous effort to stand up a new office that operates under different statutory authority than its predecessor. That said, the failure to put in place key systems and quality controls has resulted in OAWP conducting investigations that were not always thorough, objective, and unbiased—undermining OAWP’s credibility among some VA employees.

This finding discusses deficiencies that the OIG identified in the following areas:

- The OAWP lacks comprehensive policies and procedures suitable for its personnel. This is particularly important given that individuals’ reputations are at stake, whistleblowers’ identities must be protected, and the issues on which the OAWP is reporting affect veterans’ lives in tremendously significant ways. Staff are either missing guidance or are piecing together direction largely based on the mandates of a prior office not entirely aligned with OAWP’s legislative scope.
- The absence of quality control measures is particularly troubling given the hodgepodge of policies and procedures. Depending on disciplinary officials and VA’s Office of General Counsel to identify OAWP’s investigatory inadequacies cannot be a sustainable solution to effective oversight.
- The OAWP has failed to provide the staffing and training necessary to ensure it has the expertise, experience, and commitment that yield objective and thorough investigations that are critical to OAWP’s success. While the OIG appreciates the dedication and commitment of the staff within OAWP to conduct investigations, they have not been given the training and access to expertise needed to perform at the level expected of that office.
- The OAWP has fallen short of its commitment to conduct “timely, thorough, and unbiased investigations” in all cases within its investigative jurisdiction. VA employees and other complainants must be assured that OAWP investigations are conducted with the highest ethical standards, which does not yet appear to have been achieved.

The OAWP Lacked Suitable Policies and Procedures

The OAWP did not publish comprehensive policies and procedures on any topic during the tenures of then Executive Directors O’Rourke or Nicholas.⁶⁴ The OAWP continues to operate without comprehensive written policies and procedures specific to and consistent with its scope

⁶⁴ Mr. O’Rourke served as OAWP’s executive director from June 23, 2017, until February 28, 2018. Mr. Nicholas then held that position until January 25, 2019.

of authority as of July 2019, although staff reported drafting was in progress. This affected triage activities, general operations, and the integrity of investigations.

Triage Division's Procedures Blurred Scope of OAWP Authority

The Triage Division adopted written standard operating procedures (SOPs) dated August 2018 that it updated in November 2018. The triage SOPs cover many processes of the division in depth but may have perpetuated confusion about OAWP's scope of investigative authority.⁶⁵ The triage SOPs misconstrued OAWP's statutory scope, which, as discussed in Finding 1, contributed to OAWP staff

- Investigating matters outside the scope of OAWP's investigative authority,
- Failing to refer matters that should have been referred to other investigative entities, and
- Limiting investigations to submissions that met the definition of a whistleblower disclosure under the Act.

In addition, the triage SOPs do not provide direction for evaluating whether there is the risk of a conflict of interest or the appearance of bias in OAWP's acceptance of a matter for investigation.

Operational Procedures Were Incomplete and Outdated

During its review, the OIG was provided a copy of a draft manual with SOPs maintained by the OAWP Knowledge Management Division. The draft SOPs cover numerous topics, including how a matter received by the OAWP makes its way through the case process, and how the OAWP "use[s] Sharepoint to support case management and reporting." Although accessible to OAWP staff via SharePoint, the draft SOPs have not been implemented or finalized, were last updated in December 2017, and continue to reference former activities and processes of the OAR, which disbanded when the OAWP was established. In particular, with respect to report-writing guidance, the related draft SOP incorporates by reference VA Directive 0700 and VA Handbook 0700, neither of which have been adopted by the OAWP in full.

Investigations Division Used Selective Portions of Preexisting VA Procedures

The Investigations Division of the former OAR conducted its work in accordance with the policies and procedures published in VA Directive 0700 and VA Handbook 0700, both of which were last updated in 2002.⁶⁶ These policies and procedures were issued at the direction of former

⁶⁵ The categories of personnel identified in the triage SOPs as within the OAWP's scope to investigate are consistent with the February 2018 delegation but inconsistent with the Act. See Finding 1.

⁶⁶ VA Directive 0700, *Administrative Investigations*, March 25, 2002; VA Handbook 0700, *Administrative Investigations*, July 31, 2002.

VA Secretary Anthony Principi and included delegations of his authority for conducting investigations. OAWP's authority to conduct investigations comes from the Act, not from VA Directive 0700, and thus VA Directive 0700 and its related handbook are not mandatory procedures for the OAWP.⁶⁷ Former OAWP Executive Director O'Rourke told OIG investigators that the OAWP did not adopt VA Directive 0700 and VA Handbook 0700 because the procedures were "owned by OGC." Although the Act mandates that the OAWP not be established as an element of the OGC, it does not foreclose the OAWP from seeking or following legal advice provided by the OGC or from being guided by VA policies of general applicability.⁶⁸

Nevertheless, the OIG determined that the OAWP Investigations Division continued to use certain forms and processes from VA Handbook 0700, with some investigative staff confused about the extent to which the handbook applied to their operations. This confusion created unnecessary work. For example, Dr. Bonzanto told OIG investigators that she questioned OAWP staff about the necessity of preparing charge memos, documents required by VA Handbook 0700 for convening an administrative investigation board. She stated that "no one could ... explain where this all came from. They just said, well, we did that in OAR." The OIG did not assess to what extent the handbook provisions used related to any identified investigative inadequacies beyond some reported inefficiencies, but recognizes that policies and procedures should be tailored to OAWP's statutory scope and reflect standards of quality for investigations.

The OAWP Lacked Effective Quality Assurance Processes to Ensure Thorough and Accurate Investigations

The OAWP did not have measures in place to ensure that investigations met high quality standards. Quality assurance programs are fundamental for any organization but are particularly critical for those entities whose activities affect the lives and reputations of employees and the population they serve. The OIG determined that the OAWP did not implement adequate quality assurance processes designed to detect and prevent errors in its work. The A&A Division observed some deficiencies in the thoroughness of the investigations conducted by the Investigations Division. The VA Office of General Counsel also identified concerns with the

⁶⁷ In addition to the authority to investigate granted by the Act, OAWP investigators have authority to administer oaths and issue subpoenas pursuant to a specific delegation from the VA Secretary.

⁶⁸ 38 U.S.C. §323(e). VA Handbook 0700 was adopted "to standardize and enhance the efficiency and usefulness of administrative investigations within VA." The handbook states that the "provisions of this Handbook are mandatory, except where the text or context indicates otherwise." The handbook specifically excludes several types of investigations, including those conducted by the OIG and OMI. Investigations conducted by the OAWP could fit within the handbook's definition of an administrative investigation ("a systematic process for determining facts and documenting evidence about matters of significant interest to VA"), and VA could elect to require the OAWP to follow the provisions of VA Handbook 0700. The OAWP did not exist when the handbook was adopted, and VA has issued no guidance as to the handbook's applicability to the OAWP.

work conducted by both the Investigations and A&A Divisions. Neither the A&A Division nor the OGC was responsible for overseeing the work quality of investigators.

The A&A Division Identified Issues with the Thoroughness of Investigations

From June 23, 2017, until approximately March 2019, Investigations Division staff were responsible for fact-gathering as well as writing up their conclusions in an “executive summary” as to whether allegations were substantiated.⁶⁹ The investigators’ executive summaries included their conclusions and supporting evidence. The OAWP Director of Investigations (hereafter, Investigations Director) was responsible for reviewing and approving summaries. After a summary was reviewed, the investigative file and executive summary were sent to the A&A Division for review and consideration of whether disciplinary action was appropriate. As mentioned above, the A&A Division was not established to supervise the work quality of the Investigations Division, an independent coequal division. Nonetheless, during their disciplinary analysis, A&A Division staff would identify material deficiencies in the evidentiary record.

The A&A Director indicated in a March 2019 interview with OIG staff that from OAWP’s statutory inception in June 2017, she and her staff determined that there were instances in which investigations were inadequate or incomplete. When asked to describe these instances, the A&A Director attributed the shortcomings to lack of documentation, insufficient numbers of witnesses interviewed, absence of contemporaneous writings such as emails to corroborate testimony, and misinterpretations of witness statements. These shortcomings are evidenced in the following three examples.

Example 7

In September 2018, an A&A Division staff member reviewed an allegation that a supervisor retaliated against an employee who filed a grievance (a protected activity) by modifying a telework agreement, issuing written counseling, and reducing the employee’s performance rating. The Investigations Division determined that no retaliation occurred, but the A&A Division identified the following issues with the investigation: failure to develop issues raised in testimony, missing documents, omissions and inaccuracies in a timeline created by investigators based on the record, and redundant documents in the investigative file. The A&A Division recommended gathering additional documents, thoroughly reviewing all documentation, and conducting follow-up interviews. The Investigations Division responded to these concerns, agreeing to

⁶⁹ After March 2019, Dr. Bonzanto transferred the responsibility for determining whether the allegations are substantiated from the Investigation Division to the A&A Division. As a result, OAWP investigators are no longer responsible for drafting the executive summary.

follow-up interviews, but disagreeing that additional document collection was necessary as it would be “too voluminous.” After conducting additional interviews and case development, the Investigations Division maintained its original conclusion that the allegations of retaliation were not substantiated. The A&A Division rejected the Investigations Division’s conclusion and found that the evidence showed that the subject employee had experienced retaliation. A proposed notice of disciplinary action has not been issued due to additional allegations brought to the OAWP’s attention, which have not yet been resolved.

Example 8

During the review of an investigation relating to alleged retaliation in the form of removal as a contracting officer representative, an A&A Division staff member identified the following issues with the investigation: the scope of the allegations in the charge memo “provided no latitude for potential underlying misconduct that an investigation may reveal”; investigators uncovered and failed to investigate allegedly “unfounded statements” made by a subject during the investigation, which were potentially “slanderous or defamatory”; and investigators failed to consider action taken by a subject that may have been a prohibited personnel action. The Investigations Division responded to these concerns, focusing on the final one, and explained its view that the action by subject employees was not a personnel action, and thus, not retaliation. Following this response, the Investigations and A&A Divisions discussed the concerns, after which it was agreed that the retaliation allegations within OAWP’s scope were not substantiated and the matter was referred to the VA administration for further investigation of other allegations.

Example 9

An A&A Division staff member reviewed the results of an investigation into alleged prohibited personnel actions related to illegal hiring practices and retaliation. The Investigations Division substantiated the allegations that three VHA supervisory employees engaged in prohibited personnel practices and retaliation. The A&A Division staff member agreed with the Investigations Division’s conclusion as to two of the supervisory employees, but disagreed as to the third. The staff member identified the following issues with the investigation: lack of evidence and failure to state the specific prohibited personnel action at issue. The A&A Division recommended conducting follow-up interviews. The Investigations Division questioned the A&A Division’s analysis, and—apart from adding a copy of a relevant performance appraisal to its evidence—it elected not to conduct additional field work. The A&A Division continued to disagree that the

evidence was sufficient to demonstrate that the third supervisory employee engaged in prohibited personnel practices and retaliation, and instead proposed a suspension for failure to follow instructions. This proposed suspension was mitigated by the proposing official to a less severe written counseling.

The Investigations Director acknowledged that there had been occasions when the A&A Division disagreed with investigators' conclusions, but maintained they were limited to a handful of situations. When asked whether the Investigations Division has standards to determine which witnesses need to be interviewed, the Investigations Director indicated that this assessment and decision are left to the investigator, but a decision not to interview disclosing parties or subjects must be discussed with the regional directors. The Investigations Director explained that he has communicated to investigators that not every witness identified by a complainant or other witness is relevant to the investigation.

VA Office of General Counsel Attorneys Identified Deficiencies in the Work of the A&A Division and the Investigations Division

The Office of General Counsel Personnel Law Group is responsible for providing legal advice on a range of issues relating to human resources, labor relations, and security and law enforcement. The group also receives and reviews all draft proposals prepared by the A&A Division. An attorney in the group provided the OIG with multiple examples of flaws in the OAWP investigations identified through legal reviews of draft disciplinary proposals between June 23, 2017, and December 31, 2018. The flaws generally related to the sufficiency of the evidence, failure to interview witnesses with potentially exculpatory information, thoroughness, the appearance of bias, or concerns about the excessive weight that OAWP investigators ascribed to details such as a witness's demeanor.

An OGC attorney told OIG investigators that the OGC attorney's role was to advise, but not to supervise, the OAWP. The OGC could not dictate outcomes or compel the Investigations Division to interview specific witnesses. Instead, the OGC attorney reviewing the case would spot vulnerabilities in the conclusion reached by the investigator and bring those to the OAWP's attention. OAWP staff were not obligated to take OGC's advice, and in some instances officials deciding disciplinary cases (deciding officials) would independently question the evidence and learn that the OGC had previously disagreed with the OAWP's position on the sufficiency of OAWP's evidence. Former OAWP Executive Director Nicholas explained his view on addressing the OGC's concerns about the sufficiency of OAWP's evidence-gathering in this way: "At the end of the day, our job is a recommendation. The recommendation should give enough to someone to say this did happen, it is substantiated, and we need to take some action, okay? You know, don't make this into solving world hunger. It doesn't have to be that." The following example highlights the types of issues identified by the OGC attorneys.

Example 10

One OGC attorney recalled an instance in which investigators had not interviewed witnesses previously identified by the subject as individuals who could support the subject's side of the story. The existence of these witnesses was not discovered by the deciding official until the subject responded to the notice of proposed disciplinary action and again made mention of such witnesses. According to an OGC attorney familiar with the matter, it appeared that investigators had either rushed through the investigation or simply failed to interview individuals that spoke favorably about the subject. Had the investigation been thorough and all relevant evidence made available to the proposing and deciding officials, the OGC attorney posited that these officials would have received a "fair picture of the individual" at the outset versus being surprised with new information during the reply period. When an OGC attorney raised this issue with the OAWP, the investigators stated that a determination was made to not waste more resources to interview additional people. In the OGC attorney's opinion, such an approach to investigations was problematic as investigations should be thorough. OAWP's records reflect that in April 2018, the subject employee in this instance was permitted to retire pursuant to a settlement agreement.

The Investigations Division Staff Did Not All Have Appropriate Expertise and Training

Determining appropriate staff competencies and recruiting for qualified staff were challenges that the OAWP faced in establishing its new organization. Former OAWP Executive Director O'Rourke told OIG investigators that he determined that the Investigations Division needed to recruit for administrative investigators, which was not a job classification that OAWP's predecessor had used. The OAWP also faced challenges providing appropriate training for its investigators.

The Investigations Division Shifted Its Staffing Strategy Away from Human Resources Specialists

The OAWP inherited the investigative staff of the former OAR, which relied primarily on Human Resources (HR) specialists, whose position descriptions do not require extensive investigative training or experience. As of June 2018, the Investigations Division was staffed by a director, two regional supervisors, 23 HR specialists, one administrative investigator, and had five vacancies. Mr. O'Rourke told the OIG that his staffing strategy for the Investigations Division contemplated the use of administrative investigators rather than HR specialists. In his

view, the work of OAWP's Investigations Division required hiring staff with broader investigative expertise.

The OAWP began recruiting for administrative investigators in May 2018. The Investigations Director told OIG investigators that he was pleased with the recruiting effort and that it attracted many candidates with significant investigative experience. The Investigations Director also said the OAWP had explored whether it was possible to train and convert the HR specialists assigned from the OAR to become administrative investigators, but that the decision was put on hold indefinitely in December 2018. OAWP Deputy Executive Director Todd Hunter told the OIG that he was indirectly made aware that some of the HR specialists did not want to convert to administrative investigator positions and that the OAWP was "going to allow them options" because there were other roles for HR specialists. As of March 5, 2019, the staffing for the Investigations Division was composed of its director, two regional directors, 19 HR specialists, and five administrative investigators, with three vacancies. Although the composition of job types has changed slightly, the total number of staff allocated to the Investigations Division remained at 30 from June 23, 2017, to March 5, 2019.

The Investigations Division Lacked a Coordinated Strategy for Training

The Investigations Director told OIG investigators that from June 23, 2017, until approximately July 2018, the Investigations Division had only provided its staff with web-based training on Administrative Investigation Boards, which the Investigations Director described as "not very good."⁷⁰ He acknowledged that in his view, the Investigations Division staff needed better training. According to the Investigations Director, the OAWP hired a senior advisor to assist with developing training programs for investigators. That senior advisor told the OIG that OAWP investigators were not receiving adequate training on interviewing witnesses, conducting investigations, and writing reports. He also told OIG investigators that due in part to quality issues that required frequent reworking, Investigations Division staff average seven cases per year, which he viewed as insufficient productivity. As of June 2019, no internal training program had been developed.

The Investigations Director told OIG investigators that the OAWP sought to address the Investigations Division's training needs by sending staff to training sessions provided by the U.S. Department of Homeland Security's Immigration and Customs Enforcement (ICE). The Investigations Director told the OIG that ICE's Management Inquiry Training Program contained practical exercises on witness interviewing, relevant for Investigations Division staff. The Investigations Division sent six HR specialists to the training in July 2018. According to the

⁷⁰ An Administrative Investigation Board is a group of individuals appointed to analyze evidence, ascertain facts, and document complete and accurate information regarding matters of interest to VA. VA Handbook 0700, *Administrative Investigations*, July 31, 2002. The Act does not require the OAWP to use Administrative Investigation Boards for conducting its investigative work.

Investigations Director, by September 30, 2019, nearly all Investigations Division staff will have attended this training. The OAWP training participants rated the practical aspects of the program highly, but also commented that significant portions of the agenda were ICE-specific and had no application to VA.

As part of the arrangement with ICE, the Investigations Director and the senior advisor also attended a week-long advanced interviewing course and received assurance that there would be opportunities for OAWP investigators to take the course in the future. The Investigations Director found the advanced interviewing course to be highly effective and advised OIG investigators that he would like to develop a similar program internally so that OAWP can have highly trained investigators going through the right courses.

The Investigations Division Lacked a Timely, Thorough, and Balanced Approach to Fact-Finding

The OAWP did not have an approach that ensured comprehensive and impartial investigations. In part, this was because former leaders encouraged investigators to look for “substantial evidence” to support the charge of misconduct without investigating further to identify any relevant exculpatory evidence. The OAWP also conducted investigations involving political appointees instead of referring them to other qualified entities when it appeared OAWP personnel should not be involved because their ability to appear unbiased was impeded, as well as investigating one of its own directors as previously discussed. In addition, complainants voiced concern that investigations appeared to take too long, and that the OAWP did not always communicate promptly with complainants.

The Evidence Standard and Its Application Contributed to Limited and Unbalanced Investigations

In its investigations, the OAWP sought to develop “substantial evidence,” defined as “relevant evidence that a reasonable person, considering the record as a whole, might accept as adequate to support a conclusion, even though other reasonable persons might disagree.”⁷¹ That is, OAWP investigators did not conduct investigations designed to ensure that all known or obviously relevant evidence is obtained.⁷² Rather, in many instances, they focused only on finding evidence sufficient to substantiate the allegations without attempting to find potentially exculpatory or contradictory evidence. This approach was inconsistent with reliably conducting an unbiased,

⁷¹ VA adopted “substantial evidence” as the standard of proof necessary to sustain an action under the Act. Department of Veterans Affairs, Letter No. 006-17-1, Senior Exec. Accountability and Grievance Procedures (July 7, 2017).

⁷² See, e.g., Council of Inspectors General on Integrity and Efficiency, Quality Standards for Investigations (November 15, 2011). While OAWP is not governed by these standards, they provide relevant guidance for conducting thorough and objective investigations in a similar context.

balanced, and thorough investigation that includes developing relevant evidence that may disprove the allegations. In part, this was a result of failing to adopt policies and procedures requiring investigators to seek and consider contradictory or exculpatory evidence.

One deciding official described the appearance of a one-sided effort on the part of the Investigations Division stating, “[my] humble observation is that [the OAWP] had a mission to find wrongdoing.” The deciding official elaborated, “from my perspective [I] certainly received cases that I thought were marginally supported at best and that it felt like . . . there was a [disciplinary] action in search of evidence.”⁷³ In an interview with the OIG, one investigator recalled expressing a need to develop exculpatory information during the course of an investigation and being told by the A&A Director that this sort of information could be developed by the subject employee when replying to a disciplinary proposal.

Figure 3 provides an excerpt from an email with draft guidance prepared in June 2017 by a former OAWP investigator, which illustrates the impact that the substantial evidence burden of proof was anticipated to have on OAWP’s investigative work.

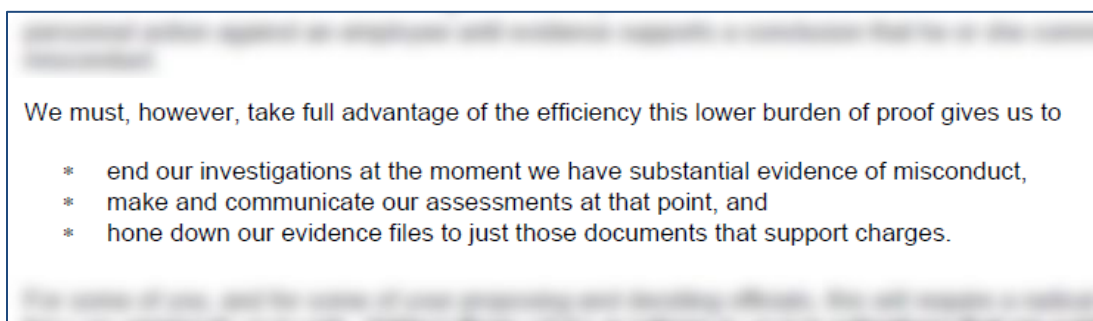


Figure 3. Excerpt of Draft Guidance Prepared for OAWP Investigative Staff

Source: VA

In response to then OAWP Executive Director O’Rourke’s request for comment concerning the draft language excerpted in Figure 3, the Investigations Director wrote, “I think it hits the nail on the head and believe it is in keeping with the Secretary’s intent. I would not change anything in it.” Although this email does not appear to have been sent as drafted to all OAWP investigators, Mr. O’Rourke instructed the Investigations Director to apply this guidance to OAWP’s investigations.⁷⁴ The Investigations Director confirmed that he expected investigators to exercise judgment and that the substantial evidence standard factors into that judgment.

⁷³ In examining whether employees were being properly held accountable under the Act’s provisions, the OIG found that in some cases, employees appeared to be facing disciplinary action without sufficient supporting evidence. See Table 2, page 40.

⁷⁴ On June 9, 2017 in anticipation of the Act’s passage, the Investigations Director emailed all investigators, instructing “Please stop what you are doing and let me [and other senior staff] know if you have any current investigations where you currently have ‘substantial evidence’ (less than preponderant evidence) substantiating misconduct.” A senior OAWP investigator explained that this was part of an effort to identify at least ten pending

In the Investigations Director's view, an investigator would be justified to cease interviewing witnesses once "four or five" witnesses provided consistent testimony because at that point substantial evidence has been marshalled. The OIG identified one instance in which OAWP investigators reached a conclusion based on evidence collected that did not include any effort to interview the subject employee.⁷⁵ The 2017 accountability procedures require that, "unless the circumstances of the investigation make it impossible, unreasonable, or unnecessary to do so, a Senior Executive who is the subject of an investigation or review will be given an opportunity to respond to and provide evidence relating to the matters under investigation."

The OIG believes that the application of the substantial evidence standard by the OAWP may have contributed to its investigations being skewed to prove charges instead of to conduct fair and comprehensive investigations. As discussed, the Investigations Division has not published any written procedures to assist investigators in the exercise of this judgment. To reach objective and balanced findings, adequate guidance and training must be provided for investigative staff to apply standards correctly. Additionally, as discussed below, OAWP's practice of only including documents that support its charges when it prepares evidence files for disciplinary cases (and not those that might be exculpatory) has injected the appearance of bias, which could undermine employees' trust in the OAWP's process.

OAWP's Investigations of Some Political Appointees Had the Appearance of Bias

The OAWP has statutory authority to investigate matters that overlaps with the authority granted several other investigative bodies, which means more than one entity can potentially investigate the same matters. The OIG identified instances in which the OAWP's objectivity was impaired by at least the appearance of bias.⁷⁶ In these instances, the OAWP should have referred the matters elsewhere or implemented measures sufficient to avoid the appearance of impropriety.⁷⁷ Key to this process is having the filter or apparatus for triaging which issues should remain within the OAWP. Guidance for employing that judgment would help ensure consistency and enhance the integrity of the office.

investigations where the OAWP could take prompt disciplinary action once the anticipated new authorities from the Act took effect. The investigator stated that Mr. O'Rourke set the goal of identifying ten actions that could be taken.

⁷⁵ See Finding 4, page 55.

⁷⁶ As discussed in Finding 1, the OAWP decided to investigate one of its directors in a case outside its statutory scope. The appearance of bias in that case was exacerbated by the slow progress of the matter at the discipline stage. Some OAWP staff familiar with the investigation questioned whether OAWP leaders were protecting a senior staff member.

⁷⁷ The OAWP has statutory authority to refer whistleblower disclosures to other investigative entities, including the OIG. 38 U.S.C. § 323(c)(1)(D).

Although the OAWP has authority to *investigate* a political appointee, the A&A Division would have no role in advising on any resulting disciplinary action.⁷⁸ The two provisions of the Act that govern the VA Secretary's authority to *take disciplinary action* against VA employees exclude political appointees.⁷⁹

The OAWP has investigated misconduct allegations brought against four political appointees: a former VA Deputy Secretary, a former VA Chief of Staff, a former VA Assistant Secretary for Human Resources and Administration, and a former VA Assistant Secretary for Operations, Security, and Preparedness. None of these cases resulted in the OAWP substantiating misconduct.

As with its other work, the OAWP has an obligation to perform its investigation of political appointees in a manner that avoids bias, both actual and apparent. The OIG identified multiple instances in which the investigation of a political appointee posed special challenges for the OAWP with respect to managing at least the appearance of bias.

Example 11

From July 2017 to November 2017, the OAWP received four submissions from four different individuals relating to allegations involving Peter Shelby, who was then serving as VA Assistant Secretary for Human Resources and Administration. The allegations included retaliation, harassment, discrimination, and creating a hostile work environment.

By the time the allegations were under OAWP review, Mr. Shelby had developed a personal relationship with Mr. O'Rourke (then the OAWP executive director) and Mr. Nicholas (then a senior advisor to the OAWP), which included golf outings and other social engagements.⁸⁰

Beyond social engagements, Mr. Shelby had influence over matters of importance to Mr. O'Rourke and Mr. Nicholas. For example, on September 19, 2017, Mr. Nicholas wrote to Mr. Shelby, "Please don't forget to see about a waiver on my retired annuity. It is a fairly large sum of money for me . . ." ⁸¹ Emails reflect that Mr. Nicholas pressed Mr. Shelby for assistance in obtaining the waiver

⁷⁸ 38 U.S.C. §§ 323(c)(1)(H), 713, and 714. In general, presidential appointees serve at the pleasure of the President. Consistent with OAWP's interpretation of its authority, political appointees are not included in the adverse action authority given to the VA Secretary in 38 U.S.C. §§ 713-714. Presidential appointees are also specifically excluded by 5 C.F.R. § 752.401 from coverage under the adverse actions provision set forth in 5 C.F.R. § 752.

⁷⁹ 38 U.S.C. § 713(d)(1)(A) and 5 U.S.C. § 3132(a)(4).

⁸⁰ Calendars and emails reflect at least five social events involving Mr. Shelby and/or Mr. O'Rourke and/or Mr. Nicholas during the OAWP investigation.

⁸¹ Like any retiree of federal service, Mr. Nicholas was subject to a prohibition against receiving the dual compensation of his federal retirement plus a federal salary. In unusual circumstances, a waiver can be obtained.

*through at least October 2017 and that the matter remained an open question through February 2018.*⁸²

Email correspondence reflects that, as of March 9, 2018, the Investigations Director had completed the OAWP investigation and was drafting the report. The report was finalized on May 21, 2018, and it concluded that allegations against Mr. Shelby were not substantiated.

With respect to the Shelby investigation, Mr. O'Rourke acknowledged there could be an appearance of bias, and told OIG investigators that because Mr. Shelby "was a political appointee, we firewall political employees away from them and give it to the career employees to investigate." The OIG determined that the OAWP had no procedures for "firewalling" its senior leaders from cases. Moreover, the OIG determined that Mr. O'Rourke personally intervened to change the investigator assigned to this matter from a career employee who was Mr. O'Rourke's indirect subordinate to the Investigations Director, who was a direct subordinate.⁸³

Mr. O'Rourke also had periodic contact with Mr. Shelby relating to the investigation while it was pending. Mr. O'Rourke told OIG investigators that Mr. Shelby "vented" to him about the investigation, and that "[Mr. Shelby] had asked [Mr. O'Rourke] about the allegations," but he told OIG investigators that any discussion was related to the allegations, not the investigation itself. On September 25, 2017, an OAWP investigator emailed Mr. Shelby to request his availability for an interview on either October 3 or 4, 2017. Mr. Shelby did not respond. On October 4, 2017, Mr. O'Rourke wrote to Mr. Shelby, "Can you make yourself available to my investigator *so we can move this along?*" (emphasis added) Later, on December 7, 2017, when the investigator contacted Mr. Shelby to inquire about a new allegation relating to an incident that occurred subsequent to his initial interview, Mr. Shelby forwarded the email to Mr. O'Rourke commenting, "Sure... I'll meet with them but this is becoming ridiculous."⁸⁴

In addition, one of the whistleblowers in the matter was a nonpolitical Covered Executive with whom Mr. O'Rourke had disagreed repeatedly. The whistleblower became the subject of an OAWP investigation requested by Mr. Shelby while the whistleblower's allegations concerning

⁸² Mr. Nicholas wrote to Mr. Shelby on October 3, 2017, "Hey Golf Pro, Any movement on my retirement waiver yet?" Mr. Shelby responded, "My best folks are on it." Emails reflect that Mr. Shelby continued following up on this request for Mr. Nicholas through at least October 2017, and a determination was made in November 2017 that Mr. Nicholas's stated justification did not meet the requirements for a waiver. Mr. Shelby resumed inquiring on behalf of Mr. Nicholas's requested waiver on February 23, 2018, in connection with an anticipated change in position for Mr. Nicholas to executive director of the OAWP.

⁸³ The investigator to whom the allegations were originally assigned was a long-tenured VA employee with more than 14 years of experience conducting investigations.

⁸⁴ The OAWP's records reflect that investigators met with Mr. Shelby for 66 minutes on October 5, 2017, and 35 minutes on December 13, 2017.

Mr. Shelby were still pending.⁸⁵ Other VA employees familiar with the case told the OIG that they were reluctant to report allegations of wrongdoing pertaining to Mr. Shelby because of their perceptions of the close relationship between Mr. O'Rourke and Mr. Shelby.

Example 12

In August 2018, the OAWP received a referral from the U.S. Office of Special Counsel and initiated an investigation into the alleged misuse of executive protection services by then VA Deputy Secretary Thomas Bowman, reportedly authorized by then Assistant Secretary for Operations, Security and Preparedness Donald Loren.⁸⁶ After interviewing Mr. Loren, the investigator determined that it would be necessary to interview the then VA General Counsel James Byrne. The investigator wanted to speak to Mr. Byrne because Mr. Loren told the investigator that he relied upon advice provided by Mr. Byrne. The Investigations Director and Mr. Nicholas intervened to prevent the investigator from interviewing Mr. Byrne. Mr. Nicholas permitted the investigator to ask the witness only three questions in written form, each of which was subject to his preapproval.⁸⁷

Example 12 evidences the need for the OAWP to have adequate procedures for mitigating the appearance of bias in cases that have the potential to jeopardize its objectivity. In this instance, Mr. Nicholas's preapproval of the content and manner of questions to be posed of a fellow political appointee has the appearance of bias.

The OIG determined that the OAWP has not instituted procedures sufficient to ensure that investigations are safeguarded against actual or perceived bias. In Example 11, the allegations of discrimination were within the purview of the Office of Resolution Management. However, given Mr. Shelby's position as the Assistant Secretary of HR&A, referral to the Office of Resolution Management—which was within HR&A—may not have avoided the appearance of bias with respect to the discrimination allegations. Instead, the allegations could have been referred to the OIG. To the extent that other allegations of misconduct on the part of Mr. Shelby could not be referred to other investigative entities, the OAWP needed to implement and adhere to procedures reasonably designed to mitigate the appearance of bias. For allegations of misconduct involving senior VA officials, the matter may be investigated by the OIG.

⁸⁵ Finding 4, page 53 presents further discussion of this case.

⁸⁶ Consistent with the ordinary process for referrals received by VA from the U.S. Office of Special Counsel, the OIG also received these allegations. The OIG did not elect to initiate an investigation of its own. In such circumstances, VA is obligated to investigate the matters raised by the U.S. Office of Special Counsel's referral.

⁸⁷ The OAWP did not substantiate misconduct in this matter. When interviewed by the OIG, the investigator expressed frustration in the limitations placed on the investigation by OAWP managers.

Investigations Did Not Meet the Timeliness Expectations of Whistleblowers

On its website, the OAWP promised “timely and unbiased investigation” of allegations and committed to “timely remedial resolutions.” The OIG received numerous complaints from whistleblowers who felt that their submissions to the OAWP were not being handled in a timely manner, and that they were not even sure that the OAWP had accepted their allegations for investigation. In one example, the OIG found that an August 2017 submission by a VA employee (a veteran) alleged supervisor retaliation, which was followed the next month by a proposed termination and same-day resignation. After a year of inaction within the Triage Division, work was undertaken for several months before the OAWP investigator learned in January 2019 that the complainant had passed away in August 2018 with the matter unresolved.

Lengthy processing times can discourage whistleblowers from making further reports.⁸⁸ The OIG recognizes, however, that investigations must be afforded adequate time to ensure accurate results. Still, the OIG evaluated the time taken by the OAWP to resolve matters that were received by the OAWP Triage Division and referred for administrative investigation and found many took a year or more to close.⁸⁹

Dr. Bonzanto told OIG investigators that she prioritized the need for prompt resolution of matters due in part to impacts on the subjects of investigations. She also stated that she was introducing standardized “touchpoints” with whistleblowers to improve communication about case statuses. She told OIG investigators that she instituted new expectations relating to timeliness of investigations. Her stated goal is to reduce to 90 days the time it takes from the receipt of a submission to the end of the A&A Division’s involvement. Dr. Bonzanto explained that she is instituting check-in points to ensure that the staff of the Investigations Division are keeping up with their workload.

⁸⁸ GAO, *Office of Special Counsel: Actions Needed to Improve Processing of Prohibited Personnel Practice and Whistleblower Disclosure Cases*, GAO-18-400, (June 2018) 16, 21, <https://www.gao.gov/assets/700/692545.pdf> (discussing importance of timeliness in resolving whistleblower claims).

⁸⁹ The data show that from June 23, 2017, through December 31, 2018, the OAWP opened 628 matters for investigation and inherited 131 matters that had been pending with the OAR. Of the 628 OAWP matters, 299 were closed by the end of 2018, but 20 took more than a year to resolve. Of the 329 matters still pending at the end of 2018, 52 had been open more than a year. According to VA’s *Administrative Investigations: Resource Guidebook* (June 2004), “[a]n administrative investigation is an impartial inquiry, authorized by a facility director or higher level manager, to be conducted at any time deemed necessary, to determine facts and collect evidence in connection with a matter in which the VA is or may be a part in interest.” Directive 0700 also provides, “The term ‘administrative investigation’ refers to a systematic process for determining facts and documenting evidence about matters of significant interest to VA.”

Finding 2 Conclusion

The lack of comprehensive written procedures has left OAWP staff without sufficient and consistent guidance for conducting its work appropriately and fairly, particularly in regard to triaging and investigating complaints. These deficiencies have perpetuated confusion about OAWP's scope of authority discussed in Finding 1. In addition, the OAWP has not had a quality assurance program to ensure investigations are thorough and accurate. OAWP also had not established training for its investigative staff, which could affect staff's ability to conduct comprehensive and balanced investigations.

The OIG determined that the OAWP has struggled to meet its commitment to objective and timely investigations. Recent complaints to OIG's hotline reflect persistent concerns regarding OAWP's investigative processes.⁹⁰ The OAWP could have avoided some of these issues by referring investigative matters to another authorized entity when OAWP's objectivity and bias would be questioned. Investigations must take sufficient time to be accurate; however, the OAWP has created a timeliness expectation for whistleblowers that it has only recently been addressing.

Recommendations 5–8

5. The Assistant Secretary for Accountability and Whistleblower Protection ensures that the divisions of the Office of Accountability and Whistleblower Protection adopt standard operating procedures and related detailed guidance to make certain they are fair, unbiased, thorough, and objective in their work.
6. The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the Office of Accountability and Whistleblower Protection, if at all.
7. The Assistant Secretary for Accountability and Whistleblower Protection assigns a quality assurance function to an entity positioned to review Office of Accountability and Whistleblower Protection divisions' work for accuracy, thoroughness, timeliness, fairness, and other improvement metrics.
8. The Assistant Secretary for Accountability and Whistleblower Protection directs the establishment of a training program for all relevant personnel on appropriate investigative techniques, case management, and disciplinary actions.

⁹⁰ Deidentified information regarding these complaints was transmitted to VA.

Finding 3: VA Has Struggled with Implementing the Act’s Enhanced Authority to Hold Covered Executives Accountable

The Act includes provisions to reduce perceived barriers to VA’s ability to hold Covered Executives accountable for misconduct and poor performance.⁹¹ These include a reduced standard of review, shorter deadlines for the presentation of defenses, and bypassing the Merit Systems Protection Board (MSPB) in favor of litigating all Covered Executive appeals directly before federal judges.⁹²

Despite statements by former VA leaders—including former Secretary Shulkin—extolling the new accountability authority, as of May 22, 2019, VA removed only one Covered Executive from federal service pursuant to the authority provided by the Act (38 U.S.C. § 713).⁹³ Other disciplinary actions, such as demotions, suspensions, and reprimands have also been taken under this authority. 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 the OAWP in 32 of the 35 Covered Executive cases that proceeded to a final decision.⁹⁴ The OIG found that the lack of adequate guidance for officials involved with the disciplinary process and the limited evidence the OAWP provided OGC and proposing officials could have led to reductions in the discipline OAWP recommended.

VA Did Not Provide Adequate Guidance for Determining Appropriate Disciplinary Actions for Covered Executives

On July 7, 2017, then VA Secretary Shulkin issued Senior Executive Accountability and Grievance Procedures for implementing the Act.⁹⁵ Those procedures adopted a decision-making process that involves three management officials: a proposing official, who suggests what disciplinary action should be taken against the subject employee; a deciding official, who issues a decision on the proposed discipline; and a grievance official, who hears an appeal from the employee. The use of a proposing official and deciding official for Covered Executive discipline

⁹¹ 38 U.S.C. § 713.

⁹² 38 U.S.C. § 713.

⁹³ This Covered Executive, the medical center director of the Washington, DC VA Medical Center, was originally removed in July 2017. The MSPB ordered a stay of VA’s removal action, the director was reinstated, and then subsequently removed under the Act’s new authority. He filed an appeal in the U.S. District Court for the District of Columbia. On May 14, 2019, VA rescinded the removal action, reinstating his employment with back pay to a different position. As of July 2, 2019, VA and the former medical center director were negotiating a settlement.

⁹⁴ Mitigation, as used here, includes instances in which the OAWP made a recommendation, but the proposing official decided not to propose any disciplinary action. A final decision includes the decision of the proposing official not to propose discipline.

⁹⁵ VA Corporate Senior Executive Management Office Letter No. 006-17-1, Senior Executive Accountability and Grievance Procedures, July 7, 2017.

cases is consistent with the decision-making approach that VA used for all staff prior to the passage of the Act.⁹⁶

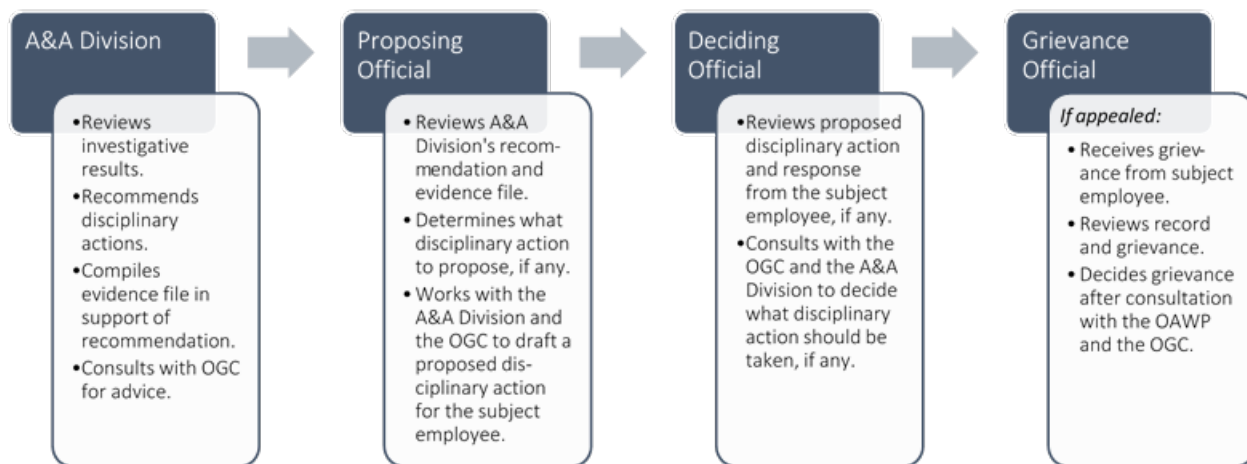


Figure 4. VA disciplinary process for Covered Executives for June 23, 2017, to June 2019

Source: OIG Analysis

VA Did Not Provide Adequate Guidance to Disciplinary Officials

Although the process is similar to prior practices, VA eliminated the use of prior guidance and failed to adopt replacement guidance for proposing and deciding officials. Previously, such decision makers consulted VA's table of penalties and the *Douglas* factors (an MSPB-compiled list of factors for deciding officials to consider when making disciplinary determinations) to aid in determining the appropriate discipline.⁹⁷ The July 2017 accountability procedures provide that the proposing official will propose "a penalty that is reasonable and commensurate with the facts."⁹⁸ The A&A Director told OIG investigators that in making their recommendations to the proposing officials, A&A Division staff attempt to be consistent with prior A&A Division recommendations for similar cases.⁹⁹ The A&A Division's recommendations are not binding,

⁹⁶ There was no requirement in the Act that VA adopt the existing model.

⁹⁷ The table of penalties is published by VA as a "guide" "in the administration of disciplinary and major adverse actions to help ensure that like actions are taken for like offenses." According to OIG interviews, it was not used in disciplinary actions under the Act because of the different standard of proof required by the Act (substantial evidence instead of preponderance of the evidence). The *Douglas* factors are a summary of factors lifted by the MSPB from court decisions, the U.S. Office of Personnel Management, and other relevant guidance that the MSPB views as "relevant for consideration in determining the appropriateness of a penalty." *Douglas v. Veterans Admin.*, 5 M.S.P.R. 280 (1981). Because senior executives are no longer able to appeal to the MSPB, VA determined that the *Douglas* factors, which are a feature of MSPB case law, do not apply to disciplinary actions under the Act.

⁹⁸ In addition, the July 2017 accountability procedures state that the degree of evidence necessary to sustain an action under 38 U.S.C. § 713 is "substantial evidence," however the application of that standard was not well understood by proposing and deciding officials.

⁹⁹ From June 23, 2017, to March 22, 2019, the A&A Division made 48 disciplinary recommendations for Covered Executives.

and the proposing official has discretion to propose whatever disciplinary actions he or she deems appropriate.

Deciding officials also have discretion to decide whether to accept, mitigate, or set aside the proposed disciplinary action. One deciding official told OIG investigators that, when determining the appropriate discipline to impose, he consulted OGC for advice in an effort to be consistent with discipline imposed in other cases. He also said that he applied his own judgment and attempted to be consistent with prior decisions he made in similar cases.

Disciplinary Officials Relied on Subjective Judgment to Decide Penalties

It is appropriate for an official to mitigate a recommended penalty due to the consideration of additional evidence or predetermined standardized disciplinary factors. It is concerning, however, when the mitigation appears to result from officials substituting their own personal judgment for consistent and defensible criteria. A large number of OAWP's recommended actions appear to have been mitigated by disciplinary officials for subjective reasons or because the investigation or evidence was not adequate.

Some OAWP officials expressed concern about the frequency with which the OAWP's recommended disciplinary actions were declined by proposing and deciding officials. The A&A Director attributed this to some disciplinary officials applying subjective mitigating factors, such as, "I've known them for 25 years and they're a great guy." The OIG's review of OAWP data shows that, of the 35 Covered Executive disciplinary cases that proceeded to a final decision from June 23, 2017, to March 22, 2019, OAWP's recommended discipline was accepted only three times.¹⁰⁰ In all other cases, a disciplinary official mitigated the recommended discipline. Eleven cases were mitigated by more than one official. In an additional five cases, the subject resigned or retired before discipline was proposed.

The OAWP provided explanations for 10 of the actions in which the disciplinary officials mitigated the action recommended by OAWP. Table 2 provides a summary (without individual identifiers) of the disciplinary officials' reasons for mitigating those 10 actions.

¹⁰⁰ As discussed in Finding 5, VA did not report on the instances in which disciplinary officials mitigated the discipline recommended by the OAWP because of the OAWP's interpretation of the Act. A final decision, as used here, includes the proposing official's decision not to propose disciplinary action.

Table 2. Reasons Officials Declined OAWP’s Recommended Actions

OAWP	Proposing Official	Deciding Official	Grievance Official	Disciplinary Officials’ Rationale ¹⁰¹
5-day suspension	no action ¹⁰²	n/a	n/a	The proposing official declined to issue any discipline because the subject’s conduct in the circumstances that gave rise to the recommendation was consistent with the way the proposing official would have conducted himself.
14-day suspension	5-day suspension	5-day suspension	n/a	Although the proposing official was comfortable with the evidence file, the penalty was lowered to a 5-day suspension. The proposing official acknowledged the mandatory minimum penalty of 12-day suspension for actions resulting from whistleblower retaliation, but interpreted the statute to be inapplicable.
15-day suspension to removal	written counseling	n/a	n/a	The proposing official consulted OGC and factored internal issues at the facility into the decision to mitigate to counseling.
removal	12-day suspension	retired in lieu of removal	n/a	The proposing official disagreed with the Office of Special Counsel’s finding and did not want to damage the subject’s career at its end.
60-day suspension	3-day suspension	reprimand	n/a	The proposing official relied upon OGC advice that OAWP’s recommendation was “too high.” The deciding official told the OAWP that he/she elected to further mitigate after “reviewing the totality of the evidence and the credibility of the witnesses.”
removal	demotion from SES to GS-14	demotion from SES to GS-14	demotion from SES to GS-15	The proposing official felt that [the subject] could still be a productive and beneficial VA employee, but not as a medical center director. The deciding official told the OAWP that he/she “concur[red] with the demotion to GS-14.” The grievance official “felt jumping to the GS14 level was too harsh.”
10-day suspension	3-day suspension	reprimand	n/a	The proposing official felt that OAWP’s recommendation was too severe. The deciding official further mitigated due to the subject’s medical condition and lack of any prior discipline.
5- to 7-day suspension	5-day suspension	written counseling	n/a	The proposing official consulted OGC because he/she disagreed with OAWP’s recommendation. The deciding official found that the evidence was insufficient.
5- to 10-day suspension	written counseling	n/a	n/a	The proposing official explained that the subject was a minor player in the action, it was a first offense and the subject’s supervisor gave him/her bad advice.
15- to 30-day suspension	no action	n/a	n/a	The proposing official relied on OGC’s advice that the Administrative Judge erred in finding discrimination, and that VA’s decision to accept that conclusion was incorrect.

Source: *OIG analysis of mitigated cases*

¹⁰¹ The rationale is based on the explanations provided by the OAWP to the OIG and is supplemented by information provided by the disciplinary officials to the OAWP.

¹⁰² “No action” means the disciplinary official declined to issue a disciplinary action and “n/a” means the corresponding disciplinary official did not have to make a decision because the disciplinary process had ended.

In nine instances, the discipline was mitigated based on the subjective judgment of the disciplinary official that OAWP's recommended action was too severe for the conduct or under the given circumstances. In at least four cases, the proposing or deciding official consulted with the OGC in reducing the discipline originally recommended by OAWP.¹⁰³ Several cases reflected concern with the thoroughness of the investigation, including the sufficiency of the evidence presented.

Proposing Officials Also Need Additional Guidance on Statutorily Mandated Adverse Actions for Whistleblower Retaliation

VA also uses proposing officials and deciding officials to determine disciplinary action in cases involving supervisors who have engaged in prohibited personnel actions.¹⁰⁴ By statute, VA is mandated to impose a minimum penalty of a 12-day suspension whenever the

Secretary, an administrative judge, the Merit Systems Protection Board, the Office of Special Counsel, an adjudicating body provided under a union contract, a Federal judge, or the Inspector General of the Department determines [a supervisor] committed a prohibited personnel action.¹⁰⁵

Second offenses carry a mandatory penalty of removal. The July 2017 accountability procedures include provisions that senior executives “will face” the mandatory penalties.

The OIG identified instances in which proposing officials would have benefited from guidance regarding mandatory minimum adverse actions beyond the admonition that senior executives “will face” the mandatory penalties. In one instance, the OAWP found a Covered Executive engaged in a prohibited personnel action, but the proposing official declined to propose the minimum 12-day suspension because he reasoned that the OAWP is not among the list of individuals identified in 38 U.S.C. § 731. In a second instance, a proposing official received a finding from the U.S. Office of Special Counsel, via the OAWP, that the subject employee (a Covered Executive) had engaged in a prohibited personnel action. The OAWP recommended removal. The proposing official (the subject's supervisor) disagreed and sought to develop evidence in support of the subject employee. In this instance, the issue became moot because the

¹⁰³ An OGC attorney explained that when OGC and the A&A Division disagreed, proposing officials were often confused about whose advice to follow.

¹⁰⁴ Although the July 2017 accountability procedures relate exclusively to Covered Executives, 38 U.S.C. § 731 applies to any supervisor found to have committed a prohibited personnel practice.

¹⁰⁵ The prohibited personnel actions described in this statutory provision relate primarily to whistleblower retaliation. 38 U.S.C. § 731(c). These mandatory minimum penalties were enacted in 2016. See *Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act*, Public Law No. 114-223, 130 Stat 857 (2016) (codified as amended at 38 U.S.C. § 731).

subject employee resigned. These examples illustrate the need for further clarification and guidance for proposing officials on when mandatory penalties should be imposed.

The A&A Division Compiled Incomplete Evidence Files to Support Proposed Disciplinary Actions

The A&A Division adopted a practice of culling OAWP’s investigative files to prepare an evidence file that it provided to the OGC and the proposing official. The A&A Division focused on including material in the evidence file that supported the proposed disciplinary action, rather than compiling all relevant evidence. According to the A&A Director, the content of the evidence file was determined by “[t]he A&A specialist. When they’re drafting the proposal, they are putting the evidence in there that they believe, as they’re drafting it, supports the charges. So, the A&A specialist makes the decision of what goes in there.”

The July 2017 accountability procedures contemplate the creation of separate investigative and evidence files, with the latter containing a subset of the evidence developed during the investigation limited to what is relevant.¹⁰⁶ Contrary to the A&A Division’s practice, however, the July 2017 procedures seem to anticipate that the evidence file made available to proposing officials would contain all relevant evidence and not simply evidence that tends to support the charges.¹⁰⁷ The July 2017 accountability procedures specifically state that the evidence file should include “[a]ny statement or evidence provided by the [Covered Executive] . . . if *relevant or used in support of the proposed action*” (emphasis added). Further, by requiring “substantial evidence” to sustain an action, the procedures imply that other relevant evidence, even if not provided by the Covered Executive, also should be included.¹⁰⁸ The July 2017 accountability procedures define “substantial evidence,” as “*relevant evidence* that a reasonable person, considering the *record as a whole* might accept as adequate to support a conclusion, even though other reasonable persons might disagree.” (emphasis added)¹⁰⁹ It would be difficult for a disciplinary official to determine whether this standard is met without considering all relevant evidence developed during the investigation.

¹⁰⁶ The OAWP’s draft SOPs reference an evidence file, developed by the investigator, to be provided to the proposing official, deciding official, and the subject. However, this requirement appears to have originated in the OAR procedures and was not updated to reflect the July 2017 accountability procedures or OAWP processes.

¹⁰⁷ The July 2017 accountability procedures do not define “relevant,” however, the Federal Rules of Evidence, for example, state that evidence is relevant if “(a) it has any tendency to make a fact more or less probable than it would be without the evidence; and (b) the fact is of consequence in determining the action.” FED. R. EVID. 401.

¹⁰⁸ The July 2017 accountability procedures state that the proposing official “shall be briefed on the investigation and the evidence be gathered” and “will review the available evidence to determine whether a Reprimand, Suspension, Demotion, or Removal should be proposed.”

¹⁰⁹ Although this standard ultimately applies to the decision of the deciding official, the July 2017 accountability procedures state that “‘No action’ may be warranted if the Proposing Official determines, by Substantial Evidence, that the evidence does not support any of the allegations against the Senior Executive.”

Example 13

After receiving investigative results from the Investigations Division, the A&A Division determined that a Covered Executive's conduct constituted neglect of duty. In February 2019, the proposing official (the Covered Executive's supervisor) issued a proposed disciplinary action and provided the Covered Executive with access to the evidence file. The OAWP's evidence file did not contain a statement prepared by the Covered Executive, referenced in his/her testimony and provided to the OAWP investigators. The statement set forth a chronology of events that appeared to conflict with the neglect of duty charge. The Covered Executive's counsel referenced this statement and its non-inclusion in the evidence file when submitting the Covered Executive's response to the deciding official. The deciding official subsequently issued a written decision referencing the materials that the Covered Executive's attorney attached to his/her response to the disciplinary proposal. The deciding official wrote, "After carefully reviewing the proposed suspension and the documentary evidence supporting the proposed action, as well as your written response to the proposed suspension, I find that the charge is not supported by substantial evidence."

With respect to Example 13, the July 2017 accountability procedures call for the inclusion of the Covered Executive's statement in the evidence file. Its non-inclusion prevented the proposing official from considering all relevant evidence.

The non-inclusion of relevant evidence in the preparation of the evidence file also impacted the OGC's ability to provide legal advice to the A&A Division. As it did with proposing officials, the A&A Division provided OGC attorneys with access to the evidence file it prepared. In September 2017, the OAWP provided an evidence file to an OGC attorney as support for a possible disciplinary action proposal. The evidence file did not contain the interview transcript of the employee who was the subject of the proposed discipline.

In response to the OGC attorney's request for access to the transcript, the A&A Director wrote,

We will not be providing the transcript [of the employee facing discipline]. It's not relevant to the charges in the proposal. I do not think it's important for the proposing official to review it, since it is not relevant. I also fail to see how a document that is not referenced in the proposal is necessary to determine whether substantial evidence exists for the charges.

The OIG concluded that the employee's transcript was relevant because it contained the subject's denials, admissions, and contextualization of alleged misconduct referenced in the proposed discipline and, therefore, should have been included in the evidence file pursuant to the July 2017 accountability procedures.

The A&A Director recalled this instance and told the OIG that then OAWP Executive Director O'Rourke directed her not to provide the transcript to the OGC attorney who requested it.¹¹⁰ The A&A Director could not recall other instances when the A&A Division denied the OGC access to requested evidence but caveated that it was “absolutely” possible.

The A&A Director told OIG investigators that, in other instances, the A&A Division would provide additional information from the investigative file if requested by the OGC. The OIG determined that this practice was problematic because OGC attorneys might not know what information to request. As one OGC attorney explained, neither the OGC attorney nor the disciplinary officials know what other information is in the investigative file until the subject responds, and even the subject might not know what is in the investigative file.¹¹¹

Under a pilot initiative implemented by Dr. Bonzanto, OGC attorneys are now routinely provided access to the entire investigative file. The results of that pilot were not yet available.

Finding 3 Conclusion

The OIG determined that VA's lack of adequate written guidance concerning penalties left disciplinary officials to largely rely upon subjective judgments in actions involving Covered Executives, which has resulted in frequent mitigation of OAWP's recommended discipline. The A&A Division also had a practice of providing only the evidence that supported the proposed action, which effectively excluded some relevant evidence from being provided to the OGC and disciplinary officials.

Recommendations 9–11

9. The VA Secretary, in consultation with the VA Office of General Counsel, provides comprehensive guidance and training reasonably designed to instill consistency in penalties for actions taken pursuant to 38 U.S.C. §§ 713 and 714.
10. The VA Secretary ensures the provision of comprehensive guidance and training to relevant disciplinary officials to maintain compliance with the mandatory adverse action criteria outlined in 38 U.S.C. § 731.
11. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that in any disciplinary action recommended by the Office of Accountability and Whistleblower Protection, all relevant evidence is provided to the VA Secretary (or the disciplinary officials designated to act on the Secretary's behalf).

¹¹⁰ The A&A Director eventually provided the transcript to the OGC attorney.

¹¹¹ This problem is exacerbated by the Act's timelines, which provide only seven business days for the subject to respond and an additional eight business days for the deciding official to process and review new information before rendering a decision. An evidence file provided by the proposing official to the deciding official with all relevant information would reduce the information the subject must collect and the deciding official must review.

Finding 4: The OAWP Failed to Fully Protect Whistleblowers from Retaliation

Under its former leadership, the OAWP did not fully exercise its authority under the Act to investigate allegations of whistleblower retaliation. Instead, it referred many complaints of whistleblower retaliation to other VA program offices, facilities, or other components that were not equipped to undertake such investigations and without adequate safeguards to protect whistleblowers' identities.

In addition, comments and actions of OAWP's former leaders evidenced that they did not properly value and respect the important role of whistleblowers in identifying fraud, waste, and abuse within the agency. Further, one of OAWP's former leaders allowed the diversion of a significant amount of resources to non-OAWP uses. Finally, the OAWP itself engaged in actions that could be considered retaliatory.

OAWP's Referral Process Did Not Ensure Thorough Investigations by Other VA Components or Have Adequate Safeguards to Protect Whistleblowers' Identities

As referenced earlier, the OAWP held itself out on its public website as conducting "thorough, timely, and unbiased investigation of all allegations and concerns."¹¹² Although OAWP does have statutory authority to investigate allegations of misconduct by Covered Executives and whistleblower retaliation by all supervisory employees, the OAWP did not investigate "all allegations and concerns" itself, but instead made more than 2,500 referrals to other VA components for investigation over the approximately 18-month review period—without always notifying the complainant of those actions. Triaging matters to ensure that OAWP's investigative resources are focused on submissions that fall squarely within its statutory scope (and raise no appearance of bias) and referring other submissions to entities best positioned to address them is not inherently problematic. The concerns raised by OAWP's referrals are primarily threefold:

1. The recipient agency must be competent to conduct the investigation of the type of matter being referred in a comprehensive, accurate, and balanced manner.
2. The OAWP must have tracking and monitoring processes to determine if the recipient entity has reasonably and appropriately handled the referral.
3. The OAWP must be transparent with complainants about the referral process and have procedures in place to ensure that complainants' identities will be protected—particularly from individuals in VA who are the subject of the allegations or are

¹¹² As detailed in Finding 1, this statement exceeds the OAWP's statutory charge. It is not empowered to investigate "all allegations and concerns," but rather only those within the ambit of its enabling statute. See 38 U.S.C. § 323(c). In July 2019, the OAWP removed this statement from its website.

positioned to identify the complainant based on the nature of the submission or other released information.

As reflected in Table 3, from June 23, 2017, to December 31, 2018, the OAWP Triage Division referred 547 submissions to the OAWP Investigations Division and 2,526 submissions to other VA components (with 38 referrals to the VA OIG).¹¹³

Table 3. OAWP Referrals – June 23, 2017, to December 31, 2018

VA Component	Count
Board of Veterans' Appeals (BVA)	21
National Cemetery Administration (NCA)	4
Office of Accountability and Whistleblower Protection (OAWP)	547
Office of Acquisition, Logistics and Construction (OALC)	7
Office of General Counsel (OGC)	6
Office of Human Resources and Administration (HR&A)	2
Office of Information and Technology (OIT)	23
Office of Inspector General (OIG)	38
Office of Medical Inspector (OMI)	13
Office of Operations, Security and Preparedness (OSP)	6
Office of Resolution Management (ORM)	8
Office of Small and Disadvantaged Business Utilization (OSDBU)	1
Office of the Secretary of Veterans Affairs	3
Veterans Benefits Administration (VBA)	205
VBA Office of Client Relations (VBA-OCR)	122
Veterans Experience Office (VEO)	2
Veterans Health Administration (VHA)	1,624
VHA Office of Client Relations (VHA-OCR)	441
Total	3,073

Source: OAWP Knowledge Management Division

¹¹³ There were 621 submissions received that OAWP triage staff did not refer because they lacked sufficient information, were duplicative, or for other reasons—bringing the total submissions to 3,694.

Some VA Components Mishandled Whistleblower Retaliation Allegations Referred by the OAWP

Of the 2,526 referrals to other VA components, at least 51 of these involved allegations of whistleblower retaliation. The Act provides that one of the functions of the OAWP is to investigate retaliation allegations lodged against any VA supervisor irrespective of GS level (or equivalent).¹¹⁴ Former OAWP Executive Director O'Rourke stated that he understood the Act to mean that the OAWP was "supposed to investigate every instance of retaliation across" the whole of VA, making "no exclusion for rank." However, he acknowledged that resource limitations played a role in the scope and referral decisions that were made. Other OAWP leaders echoed Mr. O'Rourke's sentiments about resource limitations necessitating the referral of whistleblower retaliation allegations to other VA components for investigation.

The A&A Director told OIG investigators that when she reviewed the results from investigations conducted by VA components, she identified instances in which the referral recipient concluded that no retaliation had occurred but that her review of the same evidence determined otherwise. In approximately April 2018, after assessing the results of some referred investigations, the OAWP determined that those VA components were not equipped to handle whistleblower retaliation investigations. As a result, in June 2018, the OAWP decided to begin investigating all whistleblower retaliation disclosures, including both senior executive and non-senior employees, from that point forward.¹¹⁵ When it made this change, the OAWP did not reassess investigations that had already been completed by VA components. However, these were reviewed in April and May 2019 at the direction of Dr. Bonzanto as part of an effort to examine all 539 investigations of whistleblower retaliation allegations received from June 23, 2017, through April 15, 2019, to determine if they were properly developed. This review resulted in the identification of 42 cases that merit additional review. A plan has been submitted to Dr. Bonzanto for reviewing these 42 cases.

The OAWP Faced Challenges Ensuring Follow-Up on Referrals

The former Triage Director explained to the OIG that it was a challenge to conduct follow-up once referrals were made for investigation by other VA components. She stated that the OAWP established deadlines for responses but had no ability to compel reports of work conducted. In her experience some referral recipients were responsive, but others were not.

In addition to being unable to compel reports of findings, the OIG determined that the Triage Division lacked adequate procedures for conducting follow-up. For example, email records indicate that Triage Division staff learned in March 2018 that 29 matters thought to have been referred by the OAWP to VISN 22 between July and December 2017 "fell through the cracks

¹¹⁴ 38 U.S.C. § 323(c)(1)(H).

¹¹⁵ The latest referral involving allegations of whistleblower retaliation was made on May 23, 2018.

and were not referred,” and therefore no VISN investigations had commenced. This circumstance went undetected by the OAWP for nine months.

The OAWP Referred Allegations to Other VA Components for Investigation Without Sufficiently Safeguarding Whistleblowers’ Identities

The Act provides that, with respect to whistleblower disclosures it receives, the OAWP “may not disclose the identity of the employee without the consent of the employee, except in accordance with the provisions of section 552a of title 5, or as required by any other applicable provision of Federal law.”¹¹⁶ As discussed below, the OAWP would not investigate allegations of whistleblower retaliation unless the complainant consented to disclose his or her name.

The former Triage Director told OIG investigators that individuals making submissions to the OAWP were not always informed that their allegations might be referred to another VA component for investigation. The former Triage Director stated that, for allegations other than whistleblower retaliation, if a disclosing party did not consent to the disclosure of his or her name, the party’s name was not disclosed in the referral. When asked whether steps were taken to exclude information that could be used to identify the disclosing party even if the individual’s name was redacted, the former Triage Director stated, “I believe we talked about taking those efforts, you know, because you get an email string and you can trace it back. We talked about de-identifying more than just names.” The triage SOP indicates only that case managers shall make “redacted copies of all case documents for further referral of the case outside of the OAWP,” but no guidance is provided as to what information must be redacted or how to assess whether redaction alone is sufficient to safeguard the whistleblower’s identity. This is particularly important in smaller components of VA where gender, job function, or even the nature of the complaint can trace an allegation to a specific individual.

The Investigations Director recalled situations in which the VISN receiving the referral simply directed the matter back to the very facility that the whistleblower was complaining about for investigation, which created “an obvious conflict of interest.” Similarly, the former Triage Director recalled disclosing parties expressing concerns such as “I’m say[ing] this person retaliated against me and then you’re sending it back to this facility, and although it’s not going to that same person, it’s still in that chain-of-command somehow.”

The OAWP Would Not Investigate Whistleblower Retaliation Unless the Whistleblower Consented to Disclose His or Her Identity

The OAWP took the position that allegations of whistleblower retaliation could not be investigated unless the whistleblower was willing to disclose his or her identity. The consent to disclose allowed the OAWP to further disclose the whistleblower’s identity to other VA

¹¹⁶ 38 U.S.C. § 323 (c)(3).

components. This policy places OAWP’s obligation to investigate whistleblower retaliation in conflict with its obligation to maintain confidentiality of whistleblowers’ identities. The Senior Advisor told the OIG that the OAWP adopted this policy because of the belief that to “investigate retaliation, you have almost no choice but to disclose the individual’s identity.” He said that the U.S. Office of Special Counsel takes this same position. Figure 5 displays OAWP’s advisement to disclosing parties making allegations of retaliation that has been in use since February 2018.

PART 4: CONSENT, SIGNATURE AND SUBMISSION	
1. PLEASE SELECT ONE (If you are claiming retaliation review will not be possible without your consent.):	
<input type="checkbox"/> I DO CONSENT TO RELEASE OF MY IDENTITY <input type="checkbox"/> I DO NOT CONSENT TO RELEASE OF MY IDENTITY	
2. SIGNATURE	3. DATE SUBMITTED

Figure 5. Excerpt from the disclosure form

Source: Employee Disclosure Form published by the OAWP, last revised in February 2018

In the following example, OAWP staff insisted that an allegation of whistleblower retaliation be referred to the VISN and that the employee consent to disclose his or her identity in order to make the referral, even though the allegation was within OAWP’s authority to investigate. The OAWP did not need to refer the matter to the VISN. In the end, the employee requested the OAWP stop work (and not refer the matter) pending the outcome of a related pending case with the U.S. Office of Special Counsel.

Example 14

In November 2017, a GS-13 psychologist in a VA medical center made a submission to the OAWP alleging misconduct and whistleblower retaliation. An employee with the OAWP Triage Division responded and informed the psychologist that the matter would be referred to the VISN for investigation. The consent form used by the OAWP at the time of the psychologist’s submission did not contain the disclaimer that investigations of retaliation require consent to disclosure of the whistleblower’s identity. The psychologist wanted to remain anonymous and objected to OAWP’s referral for investigation by the VISN, stating, “I guess, bottom line--the facility knows it’s me” and “I just don’t want my own HR to ‘investigate’ this and stir up yet more problems when they’ve been involved at every step.” The psychologist had a parallel case open with the Office of Special Counsel relating to the same issues. Correspondence between the psychologist and OAWP triage staff reflects that the psychologist was dissatisfied with the approach that the Office of Special Counsel was taking and wanted to pursue an alternative path. After learning that identity disclosure was required for the OAWP to proceed, the psychologist requested that the OAWP stop its work

pending the outcome of that related case. Triage Division staff subsequently closed the psychologist's case.

Although the psychologist was able to pursue allegations through a non-VA office, this example demonstrates the issues created by the OAWP's approach of referring whistleblower disclosures without adequate safeguards to protect the confidentiality of whistleblowers. It effectively closed the OAWP's doors to VA employees who alleged retaliation for whistleblowing and did not want their identities revealed to other VA components.

Investment in Former Whistleblower Mentorship Program Did Not Achieve Measurable Success and Motives for Its Creation Were Suspect

In 2017, the OAWP established a whistleblower reintegration program, which was later renamed the Whistleblower Mentorship Program. The OIG received complaints that the program was being used inappropriately to target whistleblowers.

The stated purpose of the program was to provide whistleblowers who had made complaints with transitional support resources if needed after the whistleblowing experience. The OIG recognizes that the goal of helping whistleblowers transition back into a workplace where colleagues or supervisors may be aware of allegations is laudable, but OIG interviews indicate that the motivation for the program was also focused on breaking the perceived routine of whistleblowers to continue reporting. According to then OAWP Deputy Executive Director Hunter, the purpose of the program was to "reintegrate those individuals into doing something very productive for the organization" and not become a "whistleblower as [a] profession." Stopping whistleblower activity is consistent with the complaints the OIG has received about the goals of former OAWP leaders that are detailed below.

Ultimately, in its approximately 18-month existence, the program served one whistleblower as a test case, which was described by OAWP staff as successful.¹¹⁷ Dr. Bonzanto placed the program on hold because her assessment revealed that it had not met with identifiable or measurable success sufficient to warrant devotion of the resources that would be required to expand the program to serve more individuals.¹¹⁸

¹¹⁷ The mentorship involved pairing a senior leader with the whistleblower to accomplish a local facility project. In this instance a VA medical center director agreed to mentor the whistleblower, a social worker in the medical center. The two were tasked with identifying and completing a project on which the mentor and mentee would collaborate and build a working relationship to achieve a common goal. According to OAWP staff, at the time of the program's cancellation, plans existed to expand the program to serve additional whistleblowers.

¹¹⁸ Dr. Bonzanto has alternatively considered whether there was a need to provide resources to whistleblowers who had been returned to federal service after wrongful termination, but stated that, in her view, the OAWP lacks the capacity to attend to this, and such a role is not specifically required under the Act.

Leaders' Statements on the Whistleblower Mentorship Program Evidenced an Attitude of Disfavor Toward Some Whistleblowers

The OIG received allegations from complainants characterizing the OAWP Whistleblower Mentorship Program in an unfavorable manner. Underlying these complaints was a concern that the OAWP was using the program to monitor or silence whistleblowers. The OIG confirmed that the OAWP gathered and analyzed whistleblower data from OAWP systems to identify candidates who might benefit from the mentoring services.

The OIG did not substantiate that the Whistleblower Mentorship Program was being used to silence whistleblowers. However, the OIG observed that some former OAWP leaders made statements that could be interpreted as evidencing an attitude of disfavor toward some whistleblowers. The comments by former OAWP leaders focused on a perceived need to return some whistleblowers to productive work:

- According to former OAWP Executive Director O'Rourke, VA was experiencing rampant abuse of the process by employees who would make what they deemed a whistleblower disclosure to gain protections related to activities or circumstances that did not merit such protection. Mr. O'Rourke told OIG investigators that VA has a "subculture" that evolved into a "community, a network" of whistleblowers as compared to other agencies where whistleblowing activity occurs in "isolated incidents."
- Subsequent OAWP Executive Director Nicholas told OIG investigators that from his perspective, some VA employees treat the whistleblower title as "a position description for them. They've joined Whistleblowers of America. They're in the papers. They can't seem to let go of it." He broadly characterized these employees as individuals who have "quit working or they decided that their new job was to go find more stuff to whistleblow on...and weren't performing what they had been hired to do."
- Former OAWP Deputy Executive Director Hunter told the OIG, "[u]nfortunately, some [of] our whistleblowers become career – a legacy of whistleblowers. They believe that's their only job."
- The Senior Advisor referred to the OAWP's perceived need "to get the employee out of the wearing [of] whistleblower as a [position description]. There is no job description in the federal government that says being a whistleblower is your job. You know, ...—yes, please, by all means, make the disclosure. Let us know what's wrong in the agency. We'll work on going to go fix it. But your part is done, go forth, do good, avoid evil."

The culture of an organization is determined by its leaders. Setting the tone at the top can influence internal controls and the behaviors of subordinate managers and employees.¹¹⁹

¹¹⁹ U.S. Government Accountability Office, *Standards for Internal Control in the Federal Government* (2014).

Mr. O'Rourke's perspective that VA had a problematic "subculture" of whistleblowers set an unwelcoming tone. These sentiments were communicated not just to the OIG but were also published by the OAWP in its June 2018 annual report to Congress: "An aspect of making disclosures of alleged wrongdoing is that the employee making the disclosure may feel themselves marginalized or excluded from the organizational group. Additionally, *for some employees, whistleblowing turns into an ad-hoc job description.*" (emphasis added) Although the goal of helping whistleblowers transition back into a workplace is admirable and consistent with OAWP's mission, it is not required by the Act and draws on limited OAWP resources. Even if properly supported, any such effort must be designed to support and value whistleblowers rather than characterize repeat whistleblowing as an unwelcome recidivist behavior.

Significant OAWP Resources Were Obligated for Purposes Not Related to Its Core Mission

During Mr. Nicholas's tenure, VA obligated \$2.6 million from OAWP's fiscal year 2018 budget of \$17.37 million (15 percent) on two separate contracts for process improvement and leadership development services. The first contract related to process improvements. According to Dr. Bonzanto, shortly after she became the assistant secretary she learned about the existence of the process improvement contract. She told OIG investigators that the contractor "was supposed to be helping us with our directives and our workload," but she learned after inquiring further that "everything that they were doing, none of it was related to OAWP." She also told the OIG that she ordered then Deputy Director Todd Hunter to refocus the contractor to "come back and start doing work that's related to OAWP." According to Dr. Bonzanto, by March 2019 the contractor's work was redirected to assisting the OAWP with developing its processes and procedures.

The services to be acquired under the second contract related to leadership development and coaching, which Mr. Nicholas intended for VA generally, not just the OAWP.¹²⁰ Each contract had two subsequent option years which, if exercised, would have brought the potential total obligation to over \$6.8 million. In response to the OIG's inquiry concerning the contracts, VA suspended performance on the contract for leadership development and coaching, which limited VA's cost to the \$88,000 already expended. The OIG did not find any evidence that VA leaders requested that Mr. Nicholas initiate either procurement or redirect OAWP funds to these contracts.¹²¹ The connection between these services and OAWP's core mission appears tenuous.

¹²⁰ At the same time, Mr. Nicholas told a staff member that the OAWP did not have the resources available to do the work necessary to comply with a reporting obligation mandated by Congress under §103 of the Act. See Finding 5.

¹²¹ The OIG identified evidence that the canceled contract was awarded to a vendor associated with an individual with whom Mr. Nicholas had a personal relationship, and that Mr. Nicholas had communications with this individual regarding both contractual opportunities before they were awarded. The individual was associated with vendors who bid on both contracts. Mr. Nicholas attempted unsuccessfully to cancel one of the contracts when he

The current VA chief of staff and the assistant secretary for Enterprise Integration both told OIG investigators that, in their view, attempting to address what Mr. Nicholas perceived to be VA's leadership and human resources issues was not within OAWP's mandate or Mr. Nicholas's job responsibilities.

Under Its Former Leadership, the OAWP Participated in Two Actions That Could Be Considered Retaliatory

Contrary to its core mission to protect whistleblowers, the OAWP—under Mr. O'Rourke's leadership—participated in two actions that could be considered retaliatory. The first related to the proposed removal of an OAWP employee who had made a disclosure of misconduct. The second related to the initiation of an investigation of a whistleblower who had made allegations of misconduct relating to a senior political appointee.

Mr. O'Rourke Proposed the Removal of an OAWP Employee Who Made a Protected Whistleblower Disclosure

Shortly after the OAWP was established, a senior OAWP employee (Whistleblower 1) reported that a senior VA official was interfering in a disciplinary matter and seeking to affect a predetermined outcome. This disclosure was made to then Executive Director O'Rourke and others.

According to Whistleblower 1, within a matter of days, Mr. O'Rourke downgraded Whistleblower 1's responsibilities and attempted to block Whistleblower 1 from leaving the OAWP for another job within VA. Within a few weeks, Mr. O'Rourke initiated an investigation by gathering documents and instructing the A&A Director to draft a disciplinary proposal to remove Whistleblower 1 from federal employment. Mr. O'Rourke issued a proposed removal action that Whistleblower 1 believed was calculated and timed to prevent Whistleblower 1 from starting a new job within VA. In December 2017, the OAWP rescinded its proposed removal action. Whistleblower 1 remains a VA employee (outside of the OAWP) and has a pending matter before the U.S. Office of Special Counsel relating to these circumstances.

The OAWP Failed to Guard Against the Initiation of Retaliatory Investigations

Being the subject of an investigation can be stressful, time-consuming, intimidating, and humiliating. Congress recognized the possibility that the investigative process itself could be used in a retaliatory fashion, and protected VA whistleblowers from these negative impacts by

learned that it was not awarded to the vendor associated with this individual. Given the nature of the conduct at issue, the OIG referred this matter to the U.S. Department of Justice, where it remains under review.

expanding the definition of a prohibited personnel action to include the opening of a “retaliatory investigation” against a whistleblower.¹²²

In OIG interviews, OAWP’s leaders—including former Executive Directors O’Rourke and Nicholas, the A&A Director, and the Senior Advisor—demonstrated a lack of familiarity with this statutory provision. The OIG determined that the OAWP did not design any of its processes to evaluate whether the submission of an allegation could be an effort in itself to retaliate against a whistleblower. For example, although reference is made to the prohibitions of “retaliatory investigations,” the triage SOP does not provide guidance to evaluate whether an investigation may be retaliatory, nor does it include any procedures to flag or otherwise code the incoming allegations as potentially retaliatory.

The OIG identified an instance in which the OAWP opened an investigation that could be considered retaliatory against a whistleblower. From September 2017 until at least July 2018, Peter Shelby, the then Assistant Secretary for Human Resources and Administration (HR&A), was the subject of multiple complaints lodged with the OAWP as well as the Office of Special Counsel and EEO Commission. In September 2017, a long-time career employee serving in an SES position within HR&A (Whistleblower 2) accused Mr. Shelby of violations of law including retaliation and discrimination against Whistleblower 2. Accusations made by Whistleblower 2 were investigated by the OAWP. Documents reflect that in August 2017, then OAWP Executive Director O’Rourke and Mr. Shelby began to view Whistleblower 2 as an obstacle to Mr. O’Rourke’s effort to staff the OAWP because Whistleblower 2 had concurrence authority for some hiring actions.¹²³ In addition, Mr. O’Rourke told OIG investigators that Mr. Shelby had consulted him about reassigning Whistleblower 2 and some subordinate staff to other VA positions outside of Mr. Shelby’s office.

While the allegations against Mr. Shelby were still pending, Whistleblower 2 became the subject of an OAWP investigation initiated after Mr. Shelby wrote to Mr. O’Rourke, “I am requesting an investigation and seeking disciplinary action for the pattern of negative conduct demonstrated by [Whistleblower 2].” Mr. Shelby alleged that Whistleblower 2 was “insubordinate” and had intimidated a fellow employee. Email records show that Mr. O’Rourke was personally involved in receiving the allegations from Mr. Shelby and communicating these to the OAWP staff assigned to the matter. OAWP’s records show that its investigation of Whistleblower 2 began on

¹²² 38 U.S.C. § 731(c)(3). The Act imposed a requirement that the Assistant Secretary for Accountability and Whistleblower Protection submit a report on whether VA’s investigative processes were being used to retaliate against whistleblowers. Public Law 115-41, Title I, § 103(b)(2). The OIG determined that the report submitted by the OAWP in response did not fully respond to Congress’s request. See Finding 5.

¹²³ At the time, Whistleblower 2’s job functions included concurrence authority over certain senior hiring decisions made by Mr. O’Rourke, and Whistleblower 2 had raised concerns about the number and nature of senior executive positions considered for allocation to the OAWP. Whistleblower 2 also questioned the qualifications of a candidate for a senior OAWP position who was selected by Mr. O’Rourke, but did “not appear to have any significant experience with whistleblower protections or accountability . . .”

or about January 5, 2018, and concluded nine days later.¹²⁴ An OAWP employee took testimony from a single witness concerning the alleged intimidating altercation between that witness and Whistleblower 2. The OAWP never sought any testimony or information from Whistleblower 2.¹²⁵ The OAWP staff substantiated the allegations and referred the matter directly to the A&A Division for a disciplinary recommendation without further inquiry.

In February 2018, Whistleblower 2 received information revealing that disciplinary action may be proposed against him/her, which was the first time Whistleblower 2 had any information concerning the investigation. Whistleblower 2 voluntarily sought new employment and left VA in March 2018 prior to any disciplinary action being taken.

Multiple witnesses aware of the circumstances relating to Whistleblower 2 told OIG investigators that the treatment of Whistleblower 2 had a chilling effect on their willingness to come forward with allegations of wrongdoing. One witness quoted Mr. Shelby as saying, “I’ll whip out my Accountability Act and just start firing people.” When OIG investigators questioned another witness about whether he/she had filed an OAWP complaint about some additional allegations raised concerning Mr. Shelby, the witness responded,

No, I did not, and I deliberately would never have because I didn’t trust the office since the person that I had problems with, my boss at the time, Peter Shelby, seemed to be very tight with Peter O’Rourke, who led OAWP. So, frankly, I didn’t trust the office.

Recent complaints to OIG’s hotline, although outside the scope of this review, reflect ongoing concerns about the OAWP’s commitment to preventing retaliation, including fear that raising concerns has recently resulted in, or may prompt, disciplinary action.¹²⁶

Finding 4 Conclusion

The OIG determined that, under its former leadership, the OAWP failed to take appropriate steps to protect whistleblowers, which is in direct conflict with its core mission. The OAWP referred allegations of whistleblower retaliation to other components of VA that were not equipped for such investigations, without sufficient tracking or oversight. This resulted in some cases going uninvestigated for long periods of time and without adequate safeguards to protect the identities

¹²⁴ The matter was opened and closed in fewer than nine days, compared to an average of 215 days.

¹²⁵ The OAWP was required to give a Senior Executive who is the subject of an investigation an opportunity to respond to and provide evidence relating to the matters under investigation unless the circumstances of the investigation made it impossible, unreasonable, or unnecessary to do so, VA Corporate Senior Executive Management Office Letter No. 006-17-1, Senior Executive Accountability and Grievance Procedures, July 7, 2017. The Privacy Act also requires agencies to “collect information to the greatest extent practicable directly from the subject individual when the information may result in adverse determinations about an individual’s rights, benefits, and privileges under Federal Programs.” 5 U.S.C. § 552a(e)(2).

¹²⁶ Deidentified information regarding these complaints was transmitted to the VA and the OIG will monitor VA’s response and evaluate the need for further oversight work through quarterly follow-up on open recommendations.

of whistleblowers who might be easily recognizable by the receiving facility or office. OAWP leaders lacked knowledge of processes for identifying whether accusations made to the OAWP could have been submitted to instigate an investigation as a means of retaliation. The OAWP itself participated in at least two actions that could be considered retaliatory. These actions occurred within a climate in which former leaders revealed their unfavorable opinion of some whistleblowers and focused resources on activities that did not support the core mission of the OAWP. More recent communications to the OIG hotline indicate that some individuals continue to report fear of OAWP retaliation or disciplinary action for reporting suspected wrongdoing.

Recommendations 12–14

12. The Assistant Secretary for Accountability and Whistleblower Protection implements safeguards consistent with statutory mandates to maintain the confidentiality of employees that make submissions, including guidelines for communications with other VA components.
13. The Assistant Secretary for Accountability and Whistleblower Protection leverages available resources, such as VA’s National Center for Organizational Development and the Office of Resolution Management, to conduct an organizational assessment of Office of Accountability and Whistleblower Protection employee concerns and develop an appropriate action plan to strengthen Office of Accountability and Whistleblower Protection workforce engagement and satisfaction.
14. The Assistant Secretary for Accountability and Whistleblower Protection develops a process and training for the Triage Division staff to identify and address potential retaliatory investigations.

Finding 5: VA Did Not Comply with Additional Requirements of the Act, Including Timely and Accurate Congressional Reporting

VA has failed to comply with several other requirements of the Act. For example, VA has not modified supervisors' performance plans to include criteria relating to whistleblower protection and trained employees regarding whistleblower disclosures. In addition, the OIG identified deficiencies with the reports the Act mandated that VA submit to Congress.

VA Has Failed to Revise Supervisors' Performance Plans and Provide Training as Required by the Act

The Act requires the VA Secretary, in consultation with the Assistant Secretary for Accountability and Whistleblower Protection, to “develop criteria that (1) the Secretary shall use as a critical element in any evaluation of the performance of a supervisory employee; and (2) promotes the protection of whistleblowers.”¹²⁷

The required criteria must include principles for the protection of whistleblowers. These include the degree to which supervisory employees

- Respond constructively when employees of the Department relay concerns,
- Take responsible action to resolve such concerns, and
- Foster an environment in which employees of the Department feel comfortable reporting concerns to the supervisory employees or to the appropriate authorities.¹²⁸

In addition, the Act requires VA to periodically train its supervisory employees on whistleblower rights, employee motivation, and employee performance management.¹²⁹

When asked in March 2019 whether supervisory performance plans had been modified to include the criteria required by the Act, the A&A Division Director indicated that the Senior Advisor had drafted an initial element “just to take a stab at it.” The A&A Director further explained that it was complicated “because ... it's ... a strange element to have in a performance standard because it's hard to attach a metric or any sort of ... measurement to that.” The A&A Director added that there was ultimately a question of who would be responsible for this task since adding criteria to performance appraisals “tends to be more of [a VA Human Resources and Administration] responsibility, not necessarily something that OAWP would take on.”

The Act assigns responsibility for updating supervisory performance plans to the VA Secretary, with the advice of the Assistant Secretary for Accountability and Whistleblower Protection.

¹²⁷ 38 U.S.C. § 732(a).

¹²⁸ 38 U.S.C. § 732(b).

¹²⁹ Public Law 115-41, Title II, § 209.

According to a work plan provided to the OIG by Dr. Bonzanto, the OAWP will be working with Human Resources and Administration as well as the OGC to implement this requirement. VA did not provide an update on the status of efforts to implement the requirement for periodic supervisory training, although it is listed on the chart of other responsibilities of the Act requiring implementation provided by Dr. Bonzanto.

VA Has Not Implemented Whistleblower Protection Training for All Employees as Required by the Act

The Act requires VA to provide biennial training to all employees regarding whistleblower disclosures.¹³⁰ The VA Secretary delegated this responsibility to the OAWP on February 7, 2018. In its 2018 annual report to Congress, the OAWP acknowledged that VA did not have training that met the Act's requirements. The OAWP projected that it would finalize the training materials and deployment plan by September 30, 2018. This did not occur. In his November 2018 interview with the OIG, OAWP Executive Director Nicholas acknowledged that the OAWP did not meet the deadline and that a new deadline had not been set. He explained that setting a new deadline was dependent on preparing the materials, which was difficult because of uncertainties about OAWP's scope under the statute.

In May 2019, Dr. Bonzanto told the OIG that she maintains a lengthy slide presentation that forms the basis of what this training should contain. She instructed her staff to consult with the Office of Special Counsel, the OGC, and the OIG to obtain comments, which she indicated have been received and addressed. OAWP staff have met with the VA training specialists to convert the draft presentation into training material that will be used for all VA employees. Dr. Bonzanto did not have an anticipated timeline of when the training would be complete.

VA Failed to Meet Its Statutory Obligations to Submit Multiple Congressionally Mandated Reports

The Act mandates that VA file reports providing information about accountability and whistleblower protection.¹³¹ In addition, Congress requires VA to file a report whenever disciplinary recommendations made to the VA Secretary are not taken or initiated within 60 days of the recommendation.¹³² VA's responses fell short of the statutory requirements.

¹³⁰ 38 U.S.C. § 733.

¹³¹ Public Law 115-41 §§ 211 and 103(b)(1).

¹³² 38 U.S.C. § 323(f)(2).

VA Failed to Meet Act Requirements for Its December 2017 Report to Congress Analyzing Disciplinary Outcomes for the Prior Three Years

The Act required VA to submit a report no later than December 31, 2017, detailing the “outcomes of disciplinary actions carried out by the Department of Veterans Affairs” from June 23, 2014, to June 23, 2017 (Outcomes Report).¹³³ VA failed to file this report on time, citing inadequate data. Although VA did have data challenges, this is only part of the story.¹³⁴ VA failed to disclose that the individual assigned to produce the Outcomes Report, then OAWP Executive Director Peter O’Rourke, was unaware of the requirement.

Documents show that, as of July 17, 2017, the Outcomes Report was added to VA’s master tracking list of Congressionally Mandated Reports maintained by the Office of Congressional and Legislative Affairs (OCLA). The master tracking list indicated that the Outcomes Report was assigned to Mr. O’Rourke, a copy of which was sent to him by email on July 17, 2017. The OIG could not locate any records indicating that the OAWP took any affirmative steps to prepare the Outcomes Report before its due date.

On December 28, 2017, an OCLA staff member requested a status report from Mr. O’Rourke, which prompted a series of emails between Mr. O’Rourke, the Senior Advisor, Mr. Hunter, and others within the OAWP reflecting that Mr. O’Rourke was unaware that the OAWP was responsible for the Outcomes Report. After learning from the Senior Advisor that the report would require significant effort to prepare, Mr. O’Rourke responded, “If we’re going to do it then [VA will] have to give us contract support, pulling folks off current issues to research the past makes no sense.” In a subsequent reply, Mr. O’Rourke wrote to the Senior Advisor, “We need to all get together and we’ll lead the effort -- please begin drafting a list of requirements that will satisfy the statue [sic] that can be shaped into a [Performance Work Statement for a contract proposal].”

Three weeks later, during his January 17, 2018, testimony before the Senate Committee on Veterans’ Affairs (SVAC), Secretary Shulkin stated that VA staff “had extreme difficulty tracking what you’ve required in that report prior to the implementation of the accountability act. I’ve instructed them to give whatever data they have to you and tell you what data they can collect.” He committed to submitting the Outcomes Report within two weeks. Internal emails show that the OAWP began working to devise a methodology for the report the next morning, January 18.

¹³³ Public Law 115-41 § 211. The Act required the Outcomes Report to include detailed information about VA’s disciplinary actions, including length of time actions were pending, number of steps and reviews involved, data concerning the use of alternative dispute resolution, appeals data, and information concerning the use of paid administrative leave.

¹³⁴ As discussed in Appendix A, the OAWP did not have an adequate database for tracking and managing submissions, investigations, and disciplinary actions. The OAWP is implementing new systems that are expected to streamline data collection, enhance reporting capabilities, and create efficiencies.

VA finalized its report to Congress on January 29, 2018. The report was expedited through VA's concurrence process. In June 2018, the OAWP supplemented its annual report by appending several tables of data. The material was accompanied by a disclaimer indicating that VA lacked data sufficient to conduct the effectiveness analysis mandated by the Act. According to the Senior Advisor, VA has received persistent feedback (as recently as March 2019) from staff of the House Committee on Veterans' Affairs (HVAC) and SVAC that the report submitted and its supplement were insufficient.

OAWP's Report on Investigative Methods and Retaliation Was Not Responsive to the Act's Mandate

The Act required the Assistant Secretary for Accountability and Whistleblower Protection to submit to the VA Secretary and Congress a report on the methods used to investigate VA employees (Report on Methods). The Act further required that the Report on Methods include the following:

- (1) An assessment of the use of administrative investigation boards, peer review, searches of medical records, and other methods for investigating employees of the Department.
- (2) A determination of whether and to what degree the methods described in paragraph (1) are being used to retaliate against whistleblowers.
- (3) Recommendations for legislative or administrative action to implement safeguards to prevent the retaliation described in paragraph (2).¹³⁵

The Report on Methods was submitted by VA in December 2018. It analyzed only OAWP's data, which constitutes a small fraction of investigations conducted by VA, and is not representative of all methods of investigation conducted by VA.

The Senior Advisor told OIG investigators that in July 2018, he submitted a proposal to Mr. Nicholas that the OAWP gather and analyze relevant data from various VA components. The Senior Advisor stated that Mr. Nicholas rejected the broader proposal in August 2018 because the OAWP had insufficient resources to conduct the field work.¹³⁶ Instead, Mr. Nicholas directed the Senior Advisor to "describe the investigation tools and methods that we have available in the VA and leave it at that." Although Congress allotted 18 months for VA to perform the analysis, the OAWP did not begin work on the Report on Methods until approximately two months before it was due. The Senior Advisor told OIG investigators that it

¹³⁵ Public Law 115-41 § 103(b)(1) June 23, 2017.

¹³⁶ The Act mandates the VA Secretary to "ensure that the Assistant Secretary has such staff, resources, and access to information as may be necessary to carry out the functions of the Office." 38 U.S.C. § 323(d). The OIG could locate no evidence that the OAWP ever requested resources to support the statutorily required analysis.

took him approximately a week and a half to review the relevant OAWP case files for the analysis.

VA Does Not Interpret the Act as Requiring Congressional Notification When Disciplinary Officials Decline OAWP’s Recommended Action

The Act requires the submission of a detailed report if the VA Secretary receives a recommendation for discipline from the Assistant Secretary for Accountability and Whistleblower Protection and “does not take or initiate the recommended disciplinary action” within 60 days of receipt.¹³⁷ The Act directs the VA Secretary to submit the report to the Committees on Veterans’ Affairs of both the Senate and the House of Representatives.¹³⁸ No reports have been provided to Congress pursuant to section 323(f)(2) of the Act.

On July 7, 2017, Secretary Shulkin issued the accountability procedures discussed earlier in the report, which require the OAWP to brief the Secretary on whether disciplinary action is recommended. This requirement is limited to whether an action should be pursued and not the specific action recommended. In practice, the OAWP has fulfilled this requirement by issuing a written accountability notification memorandum such as the one displayed in Figure 6.

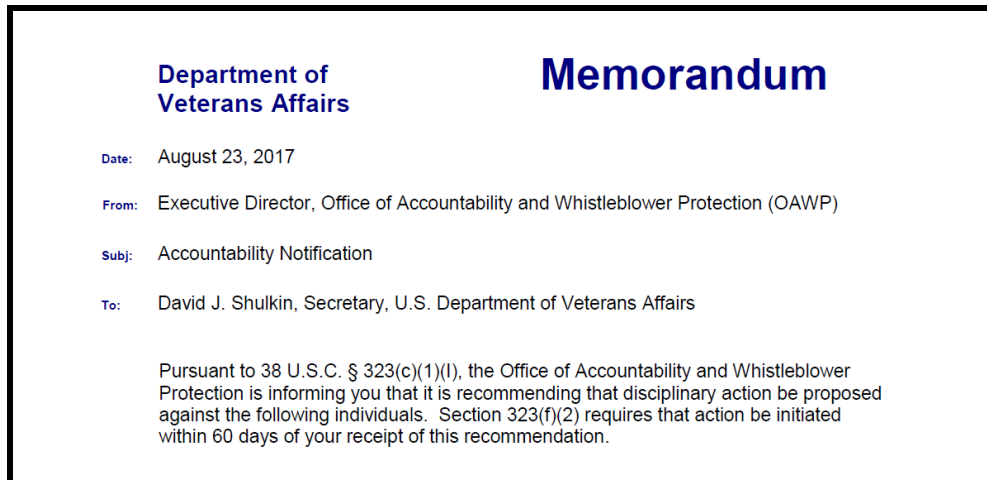


Figure 6. Sample Accountability Notification provided by the OAWP to the VA Secretary
Source: OAWP

In August 2018, staff of the HVAC majority asked VA to explain its “interpretation and implementation of the new section 323(f)(2) as it relates to congressional notification when a recommendation from OAWP is mitigated.” VA responded as follows,

Under 38 USC 323(f)(2), if “the Secretary receives a recommendation for disciplinary action” from the Assistant Secretary for Accountability and

¹³⁷ 38 U.S.C. § 323(f)(2).

¹³⁸ 38 U.S.C. § 323(f)(2).

Whistleblower Protection under 38 USC 323(c)(1)(I) and does not take or initiate the recommended disciplinary action within 60 days from the receipt of the recommendation, the Secretary must notify the House and Senate Committees on Veterans' Affairs and provide a detailed justification for not taking or initiating such disciplinary action.

VA does not have an Assistant Secretary for Accountability and Whistleblower Protection. Instead, OAWP is headed by an Executive Director. Significantly, the Executive Director for OAWP has not been delegated the functions of the Assistant Secretary for Accountability and Whistleblower Protection nor has he been designated the Acting Assistant Secretary. Instead, the Executive Director has been delegated a series of functions that are similar to, but do not mirror, the functions that would be performed by the Assistant Secretary.

As implemented by VA, the Executive Director for OAWP makes a recommendation to the Secretary for disciplinary action. The Executive Director for OAWP does not recommend a specific disciplinary action to the Secretary; rather, the recommendation is simply that "disciplinary action be proposed against" the respective employee. Following the Executive Director's recommendation, disciplinary action is *initiated* against the respective employee in that VA *begins the process of engaging* with the proposing official regarding the action and drafting a proposed charge letter. Those steps are accomplished within 60 days from the receipt of the Executive Director's recommendation to the Secretary. Consequently, VA is in compliance with 38 USC 323(f)(2) in that it initiates an action, as described above, within 60 days from the receipt of the Executive Director's recommendation to the Secretary. (emphasis added)

It is important to note that 38 USC 323(f)(2) does not require the Secretary to take the disciplinary action recommended by the Assistant Secretary for Accountability and Whistleblower Protection, even if a specific disciplinary action was recommended.¹³⁹

According to VA's response, it viewed itself compliant with section 323(f)(2) of the Act because it "begins the process of engaging with the proposing official" within 60 days of the OAWP Executive Director recommending to the VA Secretary that disciplinary action be taken. In other words, as stated in the letter, VA equates "take or initiate the recommended disciplinary action" with "begins the process of engaging with the proposing official."¹⁴⁰

¹³⁹ VA Office of Congressional and Legislative Affairs, Response to HVAC Majority, Email. (2018).

¹⁴⁰ In the response, VA noted that it did not have an assistant secretary at the time and that the executive director had not been delegated the same responsibilities. The Senior Advisor similarly told OIG investigators that VA took the

As a consequence, VA has not reported to Congress on the 32 instances from June 23, 2017, to March 22, 2019, in which the OAWP recommended a specific disciplinary action to a proposing official that was later mitigated.¹⁴¹ Notwithstanding VA's interpretation of the Act, the OAWP did track the rationale for some, but not all, instances in which recommended penalties were mitigated.¹⁴² To the extent that Congress's intent was to receive reports that illuminate the reasons why particular disciplinary actions initially recommended by OAWP were mitigated or otherwise not taken, VA has implemented the requirement in a manner that does not disclose this information.

Finding 5 Conclusion

The OIG determined that VA failed to implement various requirements under the Act, including revising supervisors' performance plans and developing supervisors' training regarding whistleblower rights. VA also has not provided whistleblower protection training for all other employees. On numerous occasions, VA did not submit timely, responsive, and/or accurate reports to Congress on whistleblower investigations and related disciplinary actions as required by the Act. The causes of these lapses included

- OAWP's lack of an adequate database system to capture required information,
- OAWP leaders' failure to understand their responsibilities and deadlines under the Act and plan accordingly, and
- OAWP's inadequate procedures or processes to track the information requested by Congress.

In addition, VA has interpreted the requirement that it submit reports to Congress when the Secretary "does not take or initiate the recommended disciplinary action" within 60 days of receipt of a recommendation in such a way that VA disciplinary officials' mitigation or declination of OAWP's recommended actions are not reported to Congress.¹⁴³ By failing to meet these statutory obligations, the OAWP has undermined Congress's intent to create greater transparency with respect to employee accountability and whistleblower protection within VA.

position that section 323(f)(2) referenced an action by the Assistant Secretary for Whistleblower Protection, and that "without an assistant secretary, that [section 323(f)(2)] did not attach to the department's actions yet."

¹⁴¹ In the July 2017 accountability procedures, the VA Secretary delegated to the proposing official the duty of reviewing the evidence and determining whether *or not* disciplinary action is warranted. This means that the VA Secretary gave the proposing official the authority to decide on behalf of the VA Secretary that no discipline is warranted.

¹⁴² Justifications for 10 mitigations are presented in Table 2 on page 40.

¹⁴³ 38 U.S.C. § 323(f)(2).

Recommendations 15–20

15. The Assistant Secretary for Accountability and Whistleblower Protection collaborates with the Assistant Secretary for Human Resources and Administration, and the VA Secretary to develop performance plan requirements as required by 38 U.S.C. § 732.
16. The Assistant Secretary for Accountability and Whistleblower Protection ensures the implementation of whistleblower disclosure training to all VA employees as required under 38 U.S.C. § 733.
17. The VA Secretary makes certain supervisors' training is implemented as required under § 209 of the VA Accountability and Whistleblower Protection Act of 2017.
18. The Assistant Secretary for Accountability and Whistleblower Protection confers with the VA Office of General Counsel to develop processes for collecting and tracking justification information related to proposed disciplinary action modifications consistent with 38 U.S.C. § 323(f)(2).
19. The VA Secretary in consultation with the Office of General Counsel and the Assistant Secretary for Accountability and Whistleblower Protection ensures compliance with the 60-day reporting requirement in 38 U.S.C. § 323(f)(2) consistent with congressional intent.
20. The Assistant Secretary for Accountability and Whistleblower Protection develops or enhances database systems to provide the capability to track all data required by the VA Accountability and Whistleblower Protection Act of 2017.

Finding 6: The OAWP Lacked Transparency in Its Information Management Practices

In the course of the OIG review, staff identified issues outside the initial scope regarding OAWP's information management practices. VA has obligations under the Privacy Act of 1974 to disclose its uses of information collected from individuals, and it has obligations under the Freedom of Information Act (FOIA) to provide timely and accurate responses to requests for information. The OAWP failed to publish notices required by the Privacy Act concerning the collection of information from individuals and VA's routine uses of that information. The OIG also found that the OAWP did not communicate appropriately with individuals who made submissions to it, and that its responses to requests for information pursuant to FOIA have not met statutory deadlines and lag significantly behind other VA components.

The OAWP Failed to File Systems of Records Notices Required by the Privacy Act

The Privacy Act's broadly stated purpose is to balance the federal government's "need to maintain information about individuals with the rights of individuals to be protected against unwarranted invasions of their privacy stemming from federal agencies' collection, maintenance, use, and disclosure of personal information about them."¹⁴⁴

The Privacy Act, which applies to all federal agencies, requires agencies to publish a System of Records Notice (SORN) in the Federal Register whenever the agency establishes or modifies an existing system of records.¹⁴⁵ A "system of records" is "a group of any records under the control of an agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying information assigned to the individual."¹⁴⁶ According to the VA Privacy Act procedures, "[t]he requirement for agencies to publish a SORN allows the Federal Government to accomplish one of the basic objectives of the Privacy Act – fostering agency accountability through public notice."¹⁴⁷

¹⁴⁴ Office of Privacy and Civil Liberties, U.S. Dept. of Justice, *Overview of the Privacy Act*, 2015.

¹⁴⁵ VA Handbook 6300.5, *Procedures for Establishing and Maintaining Privacy Act Systems of Records*, August 3, 2017.

¹⁴⁶ 5 U.S.C. § 552a(a)(5).

¹⁴⁷ VA Handbook 6300.5, *Procedures for Establishing and Maintaining Privacy Act Systems of Records*, August 3, 2017.

The OAWP Failed to Comply with the Public Notice Requirements of the Privacy Act of 1974

The OAWP assumed control of its predecessor OAR system of records on or about June 23, 2017 (the legacy records system). The legacy system was operated until May 28, 2019, when the OAWP established and began using a new system of records.¹⁴⁸ Both records systems contain the following information: the names of whistleblowers and other individuals who make submissions to the OAWP; the allegations raised by these individuals and the OAWP’s triage assessment of the allegations; data pertaining to OAWP investigations; and information relating to disciplinary actions against employees.

Records in both systems have unique case identifiers and can be retrieved using that identifier, or by searching the name of the person of interest, among other methods.¹⁴⁹ Because these records are retrievable by identifiers specific to individuals, they are considered a system of records covered by the Privacy Act. Figure 7 provides a screen capture of the Whistleblower Disclosure Tracker and the various methods by which staff could search for records, including “Disclosing Party Search,” which provides the ability to identify records by whistleblower name.

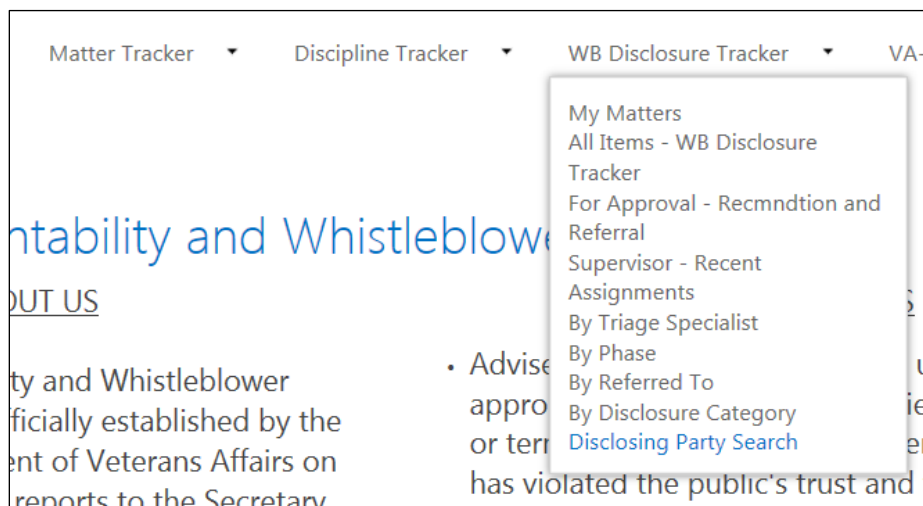


Figure 7. Screen Capture of Menu from VA OAWP Whistleblower Disclosure Tracker (May 2019).

Source: VA OAWP

¹⁴⁸ It has been preserved in a read-only state for reference purposes. Its data has been migrated to the OAWP 2019 records system.

¹⁴⁹ The VA-Wide Adverse Action Database does not appear to be searchable by name, but it was found to be a system of records subject to the Privacy Act by the arbitrator in a recent decision in a union grievance dispute between VA and the American Federation of Government Employees.

The OIG confirmed that OAWP staff are required to and did in fact search the OAWP legacy records system using individuals' names and other identifiers.¹⁵⁰ Based on the information contained in both systems and that the records in both are retrievable by identifiers specific to individuals, they are considered systems of records covered by the Privacy Act. Thus, the publication of a SORN was required with respect to both systems. The OAWP did not publish a SORN with respect to either system.

OAWP's Submission Form Does Not Disclose Routine Uses of Information as Required by the Privacy Act

The OIG interviewed several complainants who expressed dissatisfaction in the way OAWP handled their allegations. The Accountability and Whistleblower Protection Act does not impose upon the OAWP any obligation to communicate status information about its work after receiving a submission. The OIG attributes many of these complaints to OAWP's failure to adequately *disclose its uses of information* and its process for communicating about matters to people before they submit information. Individuals submitting complaints may also have their own ideas of what customer service and response style should be, based on their individual experiences with federal or private sector agencies.

The Privacy Act requires agencies to disclose to individuals supplying information the reasons that the information is being collected and the uses to which the information may potentially be put. Specifically, agencies are required to

inform each individual whom it asks to supply information, on the form which it uses to collect the information or on a separate form that can be retained by the individual – (A) the authority (whether granted by statute, or by executive order of the President) which authorizes the solicitation of the information and whether disclosure of such information is mandatory or voluntary; (B) the principal purpose or purposes for which the information is intended to be used; (C) the routine uses which may be made of the information as published pursuant to paragraph (4)(D) of this subsection; and (D) the effects on him, if any, of not providing all or any part of the requested information.¹⁵¹

The OAWP submission form in use since at least February 2018 does not include any of this information. The VA OGC advised the OAWP that the draft submission form would not need to disclose the information required by the Privacy Act unless the information would be stored in a Privacy Act System of Records. As discussed above, however, the information submitted to the

¹⁵⁰ In addition, the OIG determined that the OAWP made use of the information within its legacy tracking system to identify and analyze whistleblowers who might benefit from participation in its whistleblower reintegration program. See Finding 4, at page 50. This potential use of the individuals' data was not disclosed by the OAWP on its submission form or anywhere else.

¹⁵¹ 5 U.S.C. § 552a(e)(3).

OAWP was stored within a Privacy Act System of Records and therefore the OAWP needed to disclose the routine uses of the information being collected.

The OAWP Lags Behind the VA Average for Response Time to Requests Made Pursuant to the Freedom of Information Act

FOIA provides members of the public with a statutory right to access federal agency records, subject to certain statutory exemptions and exclusions.¹⁵² Individuals (including VA employees) who are seeking information about the activities of the OAWP can obtain information by submitting a request for information pursuant to FOIA.¹⁵³ After receiving a FOIA request, a federal agency must review its records and produce those that are not subject to an exemption or exclusion.¹⁵⁴ An agency has 20 days to review a FOIA request to determine whether to comply,¹⁵⁵ but this deadline can be extended in “unusual” circumstances.¹⁵⁶

The OIG received several complaints about OAWP’s FOIA process. According to the former Triage Director, the Triage Division also received complaints about the length of time it took for the OAWP to respond to FOIA requests. The OIG’s review of VA’s FOIA data revealed that the OAWP’s response time significantly exceeded statutorily mandated processing times and the average processing times within VA, as detailed in Table 4.

Table 4. Average Response Time for FOIA Requests Made to the OAWP from June 2017 to January 2019

Type of Request	OAWP Response Time	Overall VA Response Time
Simple	110 days	45 days
Complex	193 days	75 days

Source: VA Central FOIA Office.

Data provided by the OAWP reflects processing times ranging from five to 739 days.

¹⁵² 5 U.S.C. § 552.

¹⁵³ 5 U.S.C. § 552(a); see also https://www.oprm.va.gov/foia/howto_file_foia_request.aspx.

¹⁵⁴ 5 U.S.C. §§ 552(a)(3)(A)– (D).

¹⁵⁵ 5 U.S.C. § 552(a)(6)(A)(i).

¹⁵⁶ 5 U.S.C. § 552(a)(6)(B)(i). The deadline may be extended by up to 10 working days, but the agency must provide written notice to the requesting party detailing the unusual circumstances for such extension and the date on which a determination is expected to be made. 5 U.S.C. § 552(a)(7)(A). If the response to a FOIA request is expected to exceed 10 days, the agency is required to provide the requesting party with the tracking number assigned to the request; 5 U.S.C. § 552(a)(6)(E)(ii)(I). For expedited requests, agencies must make a determination of whether to provide expedited processing and notice of that determination must be provided to the requesting party within 10 days after the date of the request.

Email records reflect that the OAWP began focusing attention on assessing the size and status of its pending FOIA requests in August 2018, at which time the OAWP had 70 pending FOIA requests. Figure 8 depicts summary data from an internal OAWP report dated August 31, 2018:

5		
6	OAWP FOIA Summary	
7	# of Open Requests:	70
8	# of Requests Closed YTD:	4
9	Average Backlog (Days):	175
10		
11	# in Litigation:	2
12	# in Appeal:	2
13		

Figure 8. Summary Information Regarding OAWP Responses to FOIA Requests.

Source: OAWP records

OAWP staff told the OIG that the volume of FOIA requests received by the OAWP was higher than what had been experienced by its predecessor OAR, but that staffing had not increased to meet the higher demand. A single staff member handled all FOIA requests received by the OAWP until November 2018. OAWP leaders also assigned this staff member duties unrelated to FOIA request processing, including purchase and travel card management. Considering these other assigned duties, the OAWP had the equivalent of one part-time FOIA officer until November 2018.

OAWP leaders began directing additional resources to address the pending FOIA requests in approximately January 2019. OAWP data reflects that, as of February 19, 2019, the OAWP had 116 pending FOIA requests. Staffing for OAWP's FOIA group has increased from a single staff person working part time on requests to seven staff people (three of whom are on detail from the OAWP Human Resources Office) working full time on FOIA issues. Once the pending requests are resolved, the detailed staff are expected to return to their regular duties.¹⁵⁷

Finding 6 Conclusion

The OIG determined that the OAWP failed to comply with the Privacy Act by failing to publish required notices related to its systems of records, operating two unauthorized systems of records, and failing to disclose its routine uses of information submitted by individuals. In addition, the OIG determined that the OAWP did not routinely and effectively communicate to whistleblowers the status of matters they submitted and failed to provide for the timely

¹⁵⁷ These staff members did not receive any formal training regarding FOIA requests, but the OAWP's FOIA officer provided informal training in February 2019.

disclosure of information under FOIA, due in large part to insufficient staffing of the OAWP's FOIA group. The OAWP's failures to comply with the Privacy Act and inability to respond to requests for information in a timely and complete manner undermine its accountability to the public and VA stakeholders.

Recommendations 21–22

21. In consultation with the VA Office of General Counsel, the Assistant Secretary for Accountability and Whistleblower Protection completes the publication of Systems of Records Notices for all systems of records maintained by the Office of Accountability and Whistleblower Protection, and adopts procedures reasonably designed to ensure that the Office of Accountability and Whistleblower Protection does not create additional systems of records without complying with the requirements of the Privacy Act of 1974.
22. The Assistant Secretary for Accountability and Whistleblower Protection consults with the VA Chief Freedom of Information Act Officer to ensure adequate training and staffing of the Office of Accountability and Whistleblower Protection's Freedom of Information Act Office, and establishes procedures to comply with FOIA requirements including timeliness.

Conclusion

The OIG found that VA has failed to properly implement several key provisions of the VA Accountability and Whistleblower Protection Act of 2017, as well as other authorities. In particular, OAWP's former leaders failed to understand the office's statutory mandates and investigative authority. They were also ineffective at establishing clear policies, procedures, and training sufficient to ensure that the OAWP and VA met their obligations to protect whistleblowers' identities and hold VA employees accountable. Although the OIG recognizes that there have been a series of improvements planned by the Assistant Secretary in 2019, there are significant steps that must be taken to restore the trust of whistleblowers and other complainants due to missteps and a culture set by former leaders who did not appear to value their contributions. The very office established to protect whistleblowers and enhance accountability lacked the basic structures needed to achieve its core mission. Recent communications to the OIG hotline indicate that some individuals continue to report fear of OAWP retaliation or disciplinary action for reporting suspected wrongdoing. The OAWP leaders and staff who are committed to improving VA programs and operations face considerable challenges in overcoming the deficiencies identified in the OIG review.

Recommendations 1–22

1. The Assistant Secretary for Accountability and Whistleblower Protection directs a review of the Office of Accountability and Whistleblower Protection's compliance with the VA Accountability and Whistleblower Protection Act of 2017 requirements in order to ensure proper implementation and eliminate any activities not within its authorized scope.
2. The VA Secretary rescinds the February 2018 Delegation of Authority and consults with the Assistant Secretary for Accountability and Whistleblower Protection, the VA Office of General Counsel, and other appropriate parties to determine whether a revised delegation is necessary, and if so, ensures compliance with statutory requirements.
3. The Assistant Secretary for Accountability and Whistleblower Protection, in consultation with the Office of General Counsel, Office of Inspector General, Office of the Medical Inspector, and the Office of Resolution Management establishes comprehensive processes for evaluating and documenting whether allegations, in whole or in part, should be handled within the Office of Accountability and Whistleblower Protection or referred to other VA entities for potential action or referred to independent offices such as the Office of Inspector General.
4. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that policies and processes are developed, in consultation with the VA Office of General Counsel and Office of Resolution Management, to consistently and promptly advise complainants of their right to bring allegations of discrimination through the Equal Employment Opportunity process.

5. The Assistant Secretary for Accountability and Whistleblower Protection ensures that the divisions of the Office of Accountability and Whistleblower Protection adopt standard operating procedures and related detailed guidance to make certain they are fair, unbiased, thorough, and objective in their work.
6. The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the Office of Accountability and Whistleblower Protection, if at all.
7. The Assistant Secretary for Accountability and Whistleblower Protection assigns a quality assurance function to an entity positioned to review Office of Accountability and Whistleblower Protection divisions' work for accuracy, thoroughness, timeliness, fairness, and other improvement metrics.
8. The Assistant Secretary for Accountability and Whistleblower Protection directs the establishment of a training program for all relevant personnel on appropriate investigative techniques, case management, and disciplinary actions.
9. The VA Secretary, in consultation with the VA Office of General Counsel, provides comprehensive guidance and training reasonably designed to instill consistency in penalties for actions taken pursuant to 38 U.S.C. §§ 713 and 714.
10. The VA Secretary ensures the provision of comprehensive guidance and training to relevant disciplinary officials to maintain compliance with the mandatory adverse action criteria outlined in 38 U.S.C. § 731.
11. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that in any disciplinary action recommended by the Office of Accountability and Whistleblower Protection, all relevant evidence is provided to the VA Secretary (or the disciplinary officials designated to act on the Secretary's behalf).
12. The Assistant Secretary for Accountability and Whistleblower Protection implements safeguards consistent with statutory mandates to maintain the confidentiality of employees that make submissions, including guidelines for communications with other VA components.
13. The Assistant Secretary for Accountability and Whistleblower Protection leverages available resources, such as VA's National Center for Organizational Development and the Office of Resolution Management, to conduct an organizational assessment of Office of Accountability and Whistleblower Protection employee concerns and develop an appropriate action plan to strengthen Office of Accountability and Whistleblower Protection workforce engagement and satisfaction.
14. The Assistant Secretary for Accountability and Whistleblower Protection develops a process and training for the Triage Division staff to identify and address potential retaliatory investigations.

15. The Assistant Secretary for Accountability and Whistleblower Protection collaborates with the Assistant Secretary for Human Resources and Administration, and the VA Secretary to develop performance plan requirements as required by 38 U.S.C. § 732.
16. The Assistant Secretary for Accountability and Whistleblower Protection ensures the implementation of whistleblower disclosure training to all VA employees as required under 38 U.S.C. § 733.
17. The VA Secretary makes certain supervisors' training is implemented as required under § 209 of the VA Accountability and Whistleblower Protection Act of 2017.
18. The Assistant Secretary for Accountability and Whistleblower Protection confers with the VA Office of General Counsel to develop processes for collecting and tracking justification information related to proposed disciplinary action modifications consistent with 38 U.S.C. § 323(f)(2).
19. The VA Secretary in consultation with the Office of General Counsel and the Assistant Secretary for Accountability and Whistleblower Protection ensures compliance with the 60-day reporting requirement in 38 U.S.C. § 323(f)(2) consistent with congressional intent.
20. The Assistant Secretary for Accountability and Whistleblower Protection develops or enhances database systems to provide the capability to track all data required by the VA Accountability and Whistleblower Protection Act of 2017.
21. In consultation with the VA Office of General Counsel, the Assistant Secretary for Accountability and Whistleblower Protection completes the publication of Systems of Records Notices for all systems of records maintained by the Office of Accountability and Whistleblower Protection, and adopts procedures reasonably designed to ensure that the Office of Accountability and Whistleblower Protection does not create additional systems of records without complying with the requirements of the Privacy Act of 1974.
22. The Assistant Secretary for Accountability and Whistleblower Protection consults with the VA Chief Freedom of Information Act Officer to ensure adequate training and staffing of the Office of Accountability and Whistleblower Protection's Freedom of Information Act Office, and establishes procedures to comply with FOIA requirements including timeliness.

Management Comments

The Assistant Secretary for OAWP concurred on behalf of VA with all 22 OIG recommendations in the report. Comments related to individual recommendations indicate that VA considers nine recommendations to be completed based on its issuance of Directive 0500 or other recent actions.

Action plans are provided for the remaining 13 recommendations.¹⁵⁸ The Assistant Secretary for OAWP also submitted general comments which took issue with two aspects of the OIG’s report:

- (1) The OIG implies “that the [Accountability and Whistleblower Protection] Act was designed to target senior executives for discipline. In reality, the Act included expanded disciplinary authorities that apply to all VA employees...”
- (2) The OIG’s report does not address in either the executive summary or the body of the report the many improvements and reforms made by the OAWP, and instead relegates them to footnotes.

The comments in their entirety can be found in Appendix B.¹⁵⁹

OIG Response

The following responds to the two issues raised by the general comments and then outlines concerns with the VA’s proposed corrective action plans.

The first comment simply misses the point. The OIG’s report is focused on the OAWP’s operations and efforts to implement relevant sections of the Act. The expanded disciplinary authorities of the Secretary over VA employees generally, although part of the same legislation, are not directly relevant to OAWP’s operations and, thus, this report. The VA Accountability and Whistleblower Protection Act of 2017 did expand the Secretary’s disciplinary authority as to all VA employees (see 38 U.S.C. § 714), but that authority applies without regard to any involvement or action by OAWP. Indeed, the Act provides no role for OAWP in the disciplinary process of employees other than its authority to recommend discipline based on its investigation of allegations of misconduct, poor performance, and retaliation involving certain senior executives (i.e., the defined categories of Covered Executives) and allegations of retaliation on the part of supervisors.¹⁶⁰ It is this authority of the OAWP with respect to disciplinary proceedings that are addressed in this report.

Second, the report does, in fact, make multiple references in the text to OAWP progress. Moreover, as indicated by the OAWP’s comments and related action plans for each OIG recommendation, many of the improvements and reforms to which the OAWP refers largely occurred between June and October 2019 and were outside the scope of the OIG’s primary

¹⁵⁸ The OAWP states that it has taken actions that resolve 10 recommendations, but the OIG only identified nine recommendations for which the OAWP stated that actions were completed.

¹⁵⁹ The OIG publishes VA comments in full in response to every OIG report to provide VA with the opportunity to detail any accomplishments since the end of the review period and to highlight any concerns. In addition, the OIG gave the OAWP and the Office of General Counsel (OGC) an opportunity to provide technical comments to the draft during an in-person meeting on October 1, 2019.

¹⁶⁰ 38 U.S.C. § 323(c)(1)(H). The OAWP may also recommend appropriate discipline for employees based on investigations carried out by other entities such as the OIG, the Office of the Medical Inspector, and the Office of Special Counsel. 38 U.S.C. § 323(c)(1)(I).

review period, which was June 23, 2017, through December 31, 2018. Nevertheless, the OIG noted several of these efforts to acknowledge the changes the OAWP started implementing under its new leadership. Many of the issues that the OAWP purports to have “independently identified” were actually raised by the OIG during interviews with OAWP senior leaders months before any improvements were made to address these issues, as the following examples demonstrate:

- Determining when matters should be referred for review outside the OAWP (Recommendation 3) was raised as early as November 2018.
- Ensuring all relevant evidence is provided to disciplinary officials (Recommendation 11) was raised as early as March 2019.
- Maintaining the confidentiality of employees who make submissions (Recommendation 12) was raised as early as November 2018 and was brought to the direct attention of Dr. Bonzanto in April 2019.
- Developing processes for collecting and tracking justification information related to 38 U.S.C. § 323(f)(2) (Recommendation 18) was raised as early as December 2018.
- Ensuring compliance with the 60-day reporting requirement in 38 U.S.C. § 323(f)(2) (Recommendation 19) was raised in December 2018 and again in June 2019.
- Developing a database system to track all data required under the Act (Recommendation 20) was raised as early as June 2018 and continuously during interviews of OAWP senior leaders.

Concerns with VA Action Plans

The Assistant Secretary’s comments were generally responsive to the intent of the recommendations. However, some of the planned actions lacked sufficient clarity or specific steps to ensure corrective actions will adequately address the recommendations. In particular, the actions detailed in the responses to Recommendations 2, 3, 4, 7, 11, 12, 18, 19, and 20 were identified as completed as of October based on the issuance of Directive 0500 on September 10, 2019, or other actions taken in recent months. The OIG has not received sufficient documentation to determine whether recent actions and attempts to implement Directive 0500 fully address the recommendations.

The OIG notes that the planned actions for the following two recommendations do not appear sufficient to address the findings and will require updated action plans.

- **Recommendation 2.** The VA Secretary rescinds the February 2018 Delegation of Authority and consults with the Assistant Secretary for Accountability and Whistleblower Protection, the VA Office of General Counsel, and other appropriate

parties to determine whether a revised delegation is necessary, and if so, ensures compliance with statutory requirements.

The VA action plan relies on issuance of Directive 0500. That directive, however, continues to suffer from the same defects as the prior delegation, which the OIG identified in Finding 1. Specifically, it expands the scope of the OAWP's authority to investigate misconduct and poor performance for individuals other than those identified in the statute (38 U.S.C. § 323(c)(1)(H)).¹⁶¹ The OIG has seen no evidence of consultation with Office of General Counsel or other analysis to justify how such an expansion of the OAWP's investigative authority complies with statutory requirements.

- **Recommendation 12.** The Assistant Secretary for Accountability and Whistleblower Protection implements safeguards consistent with statutory mandates to maintain the confidentiality of employees that make submissions, including guidelines for communications with other VA components.

The VA's action plan states that this recommendation is resolved by VA Directive 0500, paragraph 4a(3), which requires that whistleblowers' identities for matters received by the OAWP are not disclosed without the whistleblowers' consent, except in accordance with the Privacy Act, or as required by law. This, however, may not be sufficient to resolve the OIG's recommendation if the OAWP continues its practice of requiring whistleblowers to consent to the release of their identities in order for OAWP to investigate the allegations of whistleblower retaliation. The OAWP only provides complainants with two options: to consent to release identity or not. As a result, employees could only receive OAWP's investigative services, if they consented to release and risk disclosure of their identity.¹⁶²

The OIG considers all 22 recommendations open and will monitor implementation of VA's planned and recently implemented actions to ensure that they have been effective and sustained.

¹⁶¹ The delegated authority in Directive 0500 includes the following categories of employees outside the scope of OAWP's investigative authority (unless the employee is a supervisor and the allegation is whistleblower retaliation): Senior-level (SL) positions described in 5 CFR § 319.102; Scientific and Professional (ST) positions described in 5 CFR § 319.103; Veterans law judges (including chief veterans law judges); Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) directors, associate and assistant directors at General Schedule grade 14 or above; National Cemetery Administration (NCA) cemetery directors and district chiefs of operation at General Schedule grade 14 or above; and Other SES appointees (e.g., noncareer SES appointees and limited term SES appointees).

¹⁶² In contrast, the U.S. Office of Special Counsel does not make investigations contingent on full consent and provides complainants three disclosure options related to information on their identity—full consent to disclose, consent to communicate with the agency but not disclose identity, and no consent to disclose.

Appendix A: Scope and Methodology

Scope

The OIG's review period extended from the statutory establishment of the Office of Accountability and Whistleblower Protection on June 23, 2017, through December 31, 2018. The OIG updated its fact-gathering through additional document review and interviews with the Assistant Secretary for Accountability and Whistleblower Protection and other OAWP staff in May, June, and August 2019.

Methodology

To accomplish its objectives, the OIG team reviewed applicable laws, regulations, policies, procedures, and guidelines. The OIG team interviewed 74 individuals, including current and former OAWP senior leaders Dr. Tamara Bonzanto, Peter O'Rourke, Kirk Nicholas, and Todd Hunter; current and the former OAWP Division Director, the A&A Director, and the Investigations Director; the Senior Advisor; 29 current and former OAWP employees, VA Office of General Counsel staff, current and former VA Human Resources and Administration senior leaders and staff, VA Office of the Medical Inspector staff, and U.S. Office and Special Counsel staff; and 22 complainants and complainant representatives. Additionally, the OIG team collected and reviewed emails of relevant VA staff, including OAWP staff; data from the OAWP's SharePoint database; and documents received from the OAWP in response to document requests.

In this report, the OIG has generalized narratives and case scenarios, and has removed identifiers for individuals when appropriate to protect the privacy and identity of parties and witnesses.

Scope Limitation

Prior to May 28, 2019, the OAWP managed and tracked its intake submissions, investigations, and disciplinary actions using a series of interconnected homegrown Microsoft SharePoint lists and libraries (collectively, OAWP databases). These systems were originally designed to support the workflows of the Office of Accountability Review (OAR). When the OAWP was established, the existing OAR SharePoint lists and libraries were retained and formed the basis of what became the OAWP databases. Over time, the OAWP's Knowledge Management Operations Division (KMO Division) modified the data elements collected in the OAWP databases to collect information needed for congressionally mandated reports as well as other requests from OAWP leaders. The OIG determined that while the OAWP databases lacked flexible built-in reporting capabilities, the staff of the KMO Division had sufficient expertise to extract, query, and report on the data using other software. These processes took significant

manual intervention and did not provide the KMO Division much flexibility to revise the reports to present data differently without significant additional effort.

The KMO director characterized the OAR data inherited by the OAWP as “basically unreportable because different folks were using different fields for different things, and those sorts of examples of just, you know, bad data in, bad data out.” The KMO Division has been incrementally refining the OAWP databases and standardized inputs to enforce data integrity. These refinements have applied only to newly collected data, not revisions of old records. According to the KMO director, any reporting that relied upon the OAWP databases would be “looked at very, very closely . . . to ensure that [it is] as accurate as possible.” The OAWP has implemented a new system using the Microsoft Dynamics business management platform, which is expected to have more streamlined data collection and reporting capabilities than the current OAWP databases. Additionally, the OAWP is working to create an online case submission form that will allow those reports to flow automatically into Microsoft Dynamics—creating efficiencies for the Triage Division staff currently responsible for data entry at intake.

Consistent with the KMO director’s assessment, the OIG’s review of the OAWP’s SharePoint tracking lists revealed several areas of weakness related to blank fields, duplicate options, and a lack of standardization among the three primary lists used for tracking: Disclosure Tracker, Matter Tracker, and Discipline Tracker. The OAWP advised OIG investigators that there was a lack of quality control with respect to data entry, which changed over time as measures were taken to improve data integrity. In addition, data points were added through new fields, but the preexisting records were not updated, which results in incomplete searches for queries using the added fields.

As a result of these and other limitations, the OIG cannot independently validate the OAWP’s reported data without a prohibitively resource-intensive review of all related underlying records, which may also be incomplete.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency’s *Quality Standards for Investigations*.

Appendix B: Management Comments

Department of Veterans Affairs Memorandum

Date: October 11, 2019

From: Assistant Secretary, Accountability and Whistleblower Protection (70)

Subj: VA OIG Draft Report, Office of Accountability and Whistleblower Protection: Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017 (VIEWS 01503662)

To: Inspector General (50)

1. I have reviewed the draft report and attached are general comments and responses to the recommendations. I concur with the report's 16 recommendations for the Assistant Secretary for Accountability and Whistleblower Protection. On behalf of the Department, I concur with the remained of the recommendations.
2. If you have any questions, please contact if you have questions about this information, please contact Mr. Matthew Gentil, Executive Assistant, at (202) 632-9626 or by e-mail at Matthew.Gentil@va.gov.

(Original signed by:)

Tamara Bonzanto, DNP, RN

Attachment

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

General Comment

Under the leadership of the Department of Veterans Affairs' (VA) first Assistant Secretary for Accountability and Whistleblower Protection, Dr. Tamara Bonzanto, the Office of Accountability and Whistleblower Protection (OAWP) independently identified many of the issues highlighted by the Office of Inspector General (OIG). In fact, VA has already taken and resolved ten of the OIG's recommendations. Additional improvements include:

- restructuring OAWP to facilitate better oversight;
- improving communications with whistleblowers about the status of their matters;
- ensuring OAWP directly investigates all whistleblower retaliation allegations;
- implementing an information system to track investigations and begin to identify trends, as required by the Act;
- establishing a quality review team to ensure thorough and accurate investigations; and
- developing whistleblower rights and protections training in order to better protect whistleblowers and prevent retaliation.

While OAWP continues to improve under its new leadership, VA's institutional approach to accountability is completely different than that of past administrations, and the VA Accountability and Whistleblower Protection Act of 2017 (the Act) has been a key factor in that culture change.

When problems arise, VA quickly tackles them head on, and the Act gives VA another tool to help the Department hold those responsible accountable. In fact, since June 23, 2017, when the Act became law, VA has fired more than 8,630 people.

VA takes issue with two aspects of OIG's report. The first is its implication that the Act was designed to target senior executives for discipline. In reality, the Act included expanded disciplinary authorities that apply to all VA employees compared to the 2014's Veteran Access, Choice and Accountability Act which aimed at holding only VA senior executives accountable. This is a key distinction the report misses.

VA is also concerned that the report does not address OAWP's many improvements and reforms in the executive summary or body of the report, relegating them instead to fine-print footnotes.

Regardless, VA appreciates OIG's review and is committed to consistent improvement, and under OAWP's new leadership, the office will deliver just that.

OAWP

Dr. Bonzanto appreciates the courage that it takes to report wrongdoing. Disclosures by VA employees and other individuals save Veterans' lives, combat fraud, and improves services delivered to Veterans.

Dr. Bonzanto recognizes the need for comprehensive, timely, and unbiased investigations into whistleblower disclosures, allegations of whistleblower retaliation, and allegations of senior leader misconduct and poor performance. Dr. Bonzanto recognizes the need for improvements in the way OAWP staff communicate to and about whistleblowers. Since Dr. Bonzanto's appointment, she has been assessing OAWP's operations and procedures to ensure that the organization properly implements the Act.

By April 2019, Dr. Bonzanto identified several deficiencies that needed to be corrected, including staff who were making decisions on her behalf with little to no oversight; teams who were duplicating efforts; investigators who were conducting investigations without sufficient training; a lack of communication with whistleblowers about the status of their matters; a lack of written policies and standard operating procedures; and reports and recommendations that displayed a lack of training.

Dr. Bonzanto developed and implemented a plan to correct these deficiencies. By April 2019, Dr. Bonzanto started reviewing all OAWP recommendations, including recommendations for disciplinary action or no action. She also stopped OAWP contractors from performing work unrelated to OAWP's statutory functions. She mandated that staff update whistleblowers about the status of their matters. In August 2019, Dr. Bonzanto realigned OAWP's operations to ensure that teams were not duplicating efforts and to increase the number of investigators. OAWP investigators also received training on conducting investigations in August and September 2019. OAWP is currently developing a customized investigative training course for its investigators. On September 10, 2019, VA issued Directive 0500. The directive governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct or poor performance; and allegations of whistleblower retaliation. The directive covers a number of the recommendations made by OIG.

Since her appointment in January 2019, Dr. Bonzanto made one recommendation for disciplinary action on September 20, 2019. Dr. Bonzanto recognizes that this number is low, but she believes that OAWP recommendations need to be accurate and based on thoroughly conducted investigations.

Recommendations that she received before September 2019 had several deficiencies, including:

- citing to investigative reports where witnesses were not interviewed;
- conclusory statements that were not tied into evidence; and
- failing to properly address the elements required for whistleblower retaliation.

In August 2019, OAWP developed checklists to ensure that investigative reports and recommendations addressed some of the above deficiencies. So far, the quality review team have identified discrepancies in over 45 investigative reports, which have been routed back for further investigation.

Dr. Bonzanto continues to improve OAWP operations, including ensuring that investigations are conducted in a timely and thorough manner; improving customer service; developing whistleblower rights and protections training; ensuring that OAWP complies with its statutory functions, including tracking and confirming compliance with recommendations made by OIG, VA's Office of Medical Inspector, the U.S. Government Accountability Office, and the U.S. Office of Special Counsel; and identifying trends to proactively identify areas of improvement based on data collected by OAWP.

Department of Veterans Affairs (VA) Action Plan

OIG Draft Report, Office of Accountability and Whistleblower Protection: Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017.

Date of Draft Report: September 20, 2019

Recommendation 1. The Assistant Secretary for Accountability and Whistleblower Protection directs a review of the Office of Accountability and Whistleblower Protection's compliance with the VA Accountability and Whistleblower Protection Act of 2017 requirements in order to ensure proper implementation and eliminate any activities not within its authorized scope.

VA Comment: Concur. VA is completing actions to ensure that OAWP is not performing activities outside its authorized scope or responsibilities that are unrelated to the functions specified by the Act.

Since her appointment in January 2019, the Assistant Secretary for Accountability and Whistleblower Protection has assessed OAWP's operations and procedures to ensure that the organization properly implements the Act and is operating within its authorized scope. As part OAWP's ongoing performance assessment, Dr. Bonzanto plans on having a third-party conduct an evaluation of the investigations process and compliance with the Act targeting commencement in January 2020.

Recommendation 2. The VA Secretary rescinds the February 2018 Delegation of Authority and consults with the Assistant Secretary for Accountability and Whistleblower Protection, the VA Office of General Counsel, and other appropriate parties to determine whether a revised delegation is necessary, and if so, ensures compliance with statutory requirements

VA Comment: Concur. VA is completing the actions required to resolve this recommendation in October 2019.

On October 11, 2019, the Secretary of Veterans Affairs rescinded the February 2018 delegation of authority, which is no longer needed in light of VA Directive 0500, which was issued on September 10, 2019.

Recommendation 3. The Assistant Secretary for Accountability and Whistleblower Protection, in consultation with the Office of General Counsel, Office of Inspector General, Office of the Medical Inspector, and the Office of Resolution Management establishes comprehensive processes for evaluating and documenting whether allegations, in whole or in part, should be handled within OAWP or referred to other VA entities for potential action or referred to independent offices such as the Office of Inspector General.

VA Comment: Concur. VA completed the actions required to resolve this recommendation in September 2019.

VA Directive 0500, issued on September 10, 2019, governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct or poor performance; and allegations of whistleblower retaliation. The directive identifies matters that are more appropriately addressed by other remedial administrative processes, including equal employment opportunity allegations and hostile work environment allegations. Individuals making these allegations are notified that OAWP does not

investigate them and are provided information on the right forum to file their complaint. Allegations involving actual or potential crimes are sent to OIG for review. Templates and guidance about these processes have been disseminated to staff.

Recommendation 4. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that policies and processes are developed, in consultation with the VA Office of General Counsel and Office of Resolution Management, to consistently and promptly advise complainants of their right to bring allegations of discrimination through the Equal Employment Opportunity process.

VA Comment: Concur. VA completed the actions required to resolve this recommendation in September 2019.

VA Directive 0500, issued on September 10, 2019, governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct or poor performance; and allegations of whistleblower retaliation. The directive identifies matters that are more appropriately addressed by other remedial administrative processes, including equal employment opportunity allegations and hostile work environment allegations. Individuals making these allegations to OAWP are notified that OAWP does not investigate them and are provided information on the right forum to file their complaint. Templates and guidance about these processes have been disseminated to staff.

Recommendation 5. The Assistant Secretary for Accountability and Whistleblower Protection ensures that the divisions of the Office of Accountability and Whistleblower Protection adopt standard operating procedures and related detailed guidance to make certain they are fair, unbiased, thorough, and objective in their work.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

The Assistant Secretary recognizes that the actions of OAWP staff must be unbiased, thorough, and objective. The Assistant Secretary is taking a number of steps to ensure that this occurs, including:

- issuing VA Directive 0500 on September 10, 2019. The directive governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct or poor performance; and allegations of whistleblower retaliation;
- establishing a quality review team to ensure thorough and accurate investigations;
- developing a comprehensive training program for its investigators. The program will cover investigative techniques, including report writing. The program will incorporate best practices from the Office of Special Counsel (OSC), the Council of Inspectors General on Integrity and Efficiency (CIGIE), and other governmental and non-governmental offices. This will serve as the foundation for continuous professional training and development that will be conducted throughout the next fiscal year;
- developing a comprehensive training program for individuals who review investigative reports to ensure the reports are done in a fair, unbiased, thorough, and objective manner. The program will incorporate best practices from OSC, CIGIE, and other governmental and non-governmental offices;
- developing standard operating procedures (SOP), checklists, and a reporting template to ensure consistent quality and timeliness with OAWP investigations;

- developing additional SOPs and policy as it complies with the other provisions of 38 United States Code (U.S.C.) § 323, including tracking and confirming the implementation of recommendations made by the Government Accountability Office, OSC, the Office of Medical Inspector, and OIG;
- ensuring that all staff are trained in and held accountable for providing customer service; and
- establishing a customer survey to measure the impact of these customer service improvements.

Recommendation 6. The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the Office of Accountability and Whistleblower Protection, if at all.

VA Comment: Concur. OAWP is not an element of the Office of General Counsel (OGC) and does not report to the General Counsel.

With regard to VA Directive 0700 and VA Handbook 0700, VA is taking actions required to resolve this recommendation and anticipates completing these actions by early 2020. OGC assigned a workgroup the task of updating VA Directive 0700 and VA Handbook 0700. The update will include clarification of the extent, if any, the Directive and Handbook apply to OAWP. As required under VA policy, impacted VA offices, including OAWP, will provide feedback on the Directive and Handbook.

Recommendation 7. The Assistant Secretary for Accountability and Whistleblower Protection assigns a quality assurance function to an entity positioned to review OAWP divisions' work for accuracy, thoroughness, timeliness, fairness, and other improvement metrics.

VA Comment: Concur. VA completed the actions required to resolve this recommendation in August 2019.

The Assistant Secretary recognizes that the actions of OAWP staff must be unbiased, thorough, and objective. In August of 2019, OAWP underwent a realignment of its operations to ensure quality performance: investigate matters on a timely basis; prepare and issue recommendations on a timely basis; reduce its backlog of cases and ensure that it can comply with the other provisions of 38 U.S.C. § 323. As part of this realignment, OAWP established a quality review team to ensure thorough and accurate investigations.

OAWP is developing a comprehensive training program for individuals who review investigative reports to ensure the reports are done in a fair, unbiased, thorough, and objective manner. The program will incorporate best practices from OSC, CIGIE, and other governmental and non-governmental offices. The quality review team is also developing SOPs, checklists, and a reporting template to ensure consistent quality and timeliness with OAWP investigations.

Recommendation 8. The Assistant Secretary for Accountability and Whistleblower Protection directs the establishment of a training program for all relevant personnel on appropriate investigative techniques, case management, and disciplinary actions.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

The Assistant Secretary recognizes that the actions of OAWP staff must be unbiased, thorough, and objective. OAWP is developing a comprehensive training program for its investigators. The program will cover investigative techniques, including report writing. The program will incorporate best practices from OSC, CIGIE, and other governmental and non-governmental offices. This will serve as the foundation of continuous professional training and development that will be conducted throughout the next fiscal year.

OAWP investigators have already started to receive standardized training on conducting investigations, which was presented in August and September 2019.

Recommendation 9. The VA Secretary, in consultation with the VA Office of General Counsel, provides comprehensive guidance and training reasonably designed to instill consistency in penalties for actions taken pursuant to 38 U.S.C. §§ 713 and 714.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions by the end of the calendar year.

Office of Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP) will prepare guidance regarding penalty selection for actions taken pursuant to 38 U.S.C. §§ 713 and 714. VA Handbook 5021 will be modified to incorporate this guidance. The guidance will be consistent with the authorities provided to the VA by Public Law 115-41, Executive Order 13839, and recent Office of Personnel Management comments posted in the Federal Register regarding Agency use of a Table of Penalties.

Recommendation 10. The VA Secretary ensures the provision of comprehensive guidance and training to relevant disciplinary officials to maintain compliance with the mandatory adverse action criteria outlined in 38 U.S.C. § 731

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

HRA/OSP will issue guidance clarifying the procedures for actions taken under 38 U.S.C. § 731. VA Handbook 5021 will be modified to incorporate this guidance, and VA's enterprise-wide employee relations case management system will be used to maintain relevant evidence provided to the VA Secretary (or the designated disciplinary officials) and monitor compliance with the guidance.

Recommendation 11. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that in any disciplinary action recommended by the OAWP, all relevant evidence is provided to the VA Secretary (or the disciplinary officials designated to act on the Secretary's behalf).

VA Comment: Concur. VA completed the actions required to resolve this recommendation in September 2019.

As described in VA Directive 0500, issued on September 10, 2019, OAWP no longer provides Human Resources (HR) services. Instead, these services are provided directly by HR servicing offices. In the case of senior executives, that would be the Corporate Senior Executive Management Office.

As required under VA Directive 0500, OAWP provides disciplinary officials with recommendations for disciplinary action and also provides those officials with access to the investigative file, so that they can consider it when deciding whether to propose or take a disciplinary action.

Recommendation 12. The Assistant Secretary for Accountability and Whistleblower Protection implements safeguards consistent with statutory mandates to maintain the confidentiality of employees that make submissions, including guidelines for communications with other VA components.

VA Comment: Concur. VA completed the actions required to resolve this recommendation in September 2019.

VA Directive 0500, paragraph 4a(3), requires that whistleblowers' identities for matters received by OAWP are not disclosed without the whistleblowers' consent, except in accordance with the Privacy Act, or as required by law.

When allegations are received, OAWP staff ask the individual whether they would like to remain anonymous. If so, OAWP staff go through a list of questions to determine what information the individual is willing to disclose and whether there are restrictions on sharing the information with specific individuals. Before referring a matter for investigation, OAWP redacts any information that the individual is not willing to disclose or identifies individuals who should not undertake the investigation. If an investigation is conducted by OAWP staff, staff abides by the restrictions on the disclosure of the individual's identity.

Additional training will be provided to staff about interacting with and conducting investigations regarding individuals who chose to remain anonymous.

Recommendation 13. The Assistant Secretary for Accountability and Whistleblower Protection leverages available resources, such as VA's National Center for Organizational Development and the Office of Resolution Management, to conduct an organizational assessment of OAWP employee concerns and develop an appropriate action plan to strengthen OAWP workforce engagement and satisfaction.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

VA's National Center for Organizational Development (NCOD) reviewed the results of OAWP's 2019 All Employee Survey with OAWP's management. Notably, the survey was conducted in June 2019, during a key transition point for OAWP when changes to bring the organization into alignment with the statute were underway. OAWP continues to engage with NCOD to improve OAWP workforce engagement and satisfaction.

OAWP is also establishing four employee workgroups, designed to solicit employee feedback as OAWP continues its realignment. The workgroups include a training workgroup, which will advise on training that is beneficial for OAWP staff; policy/process workgroup, which will advise on SOPs and policy for OAWP; employee engagement workgroup, which will advise on ways to improve employee engagement; and a technology workgroup, which will advise on ways to better utilize technology in OAWP.

OAWP is also collaborating with the Veterans Experience Office (VEO) to provide customer service training to all staff. OAWP is also working with VEO to develop a customer survey to measure the impact of these customer service improvements.

Recommendation 14. The Assistant Secretary for Accountability and Whistleblower Protection develops a process and training for the Triage Division staff to identify and address potential retaliatory investigations.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

On August 18, 2019, OAWP realigned staff and offices to ensure that it can: investigate matters on a timely basis; prepare and issue recommendations on a timely basis; reduce its backlog of cases and ensure that it can comply with the other provisions of 38 U.S.C. § 323. As part of this realignment, the Triage team was eliminated, and its responsibility for the informal development of matters was moved to the Investigations team to prevent a duplication of effort by both teams. The realignment did not result in a reduction in grade or a loss of pay for any OAWP employee.

OAWP will collaborate with OSC and consult with OGC on ways to help train OAWP staff to identify and address potential retaliatory investigations.

Recommendation 15. The Assistant Secretary for Accountability and Whistleblower Protection collaborates with the Assistant Secretary for Human Resources and Administration, and the VA Secretary to develop performance plan requirements as required by 38 U.S.C. § 732.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

HRA/OSP collaborated with OAWP to develop criteria as required by 38 U.S.C. § 732. The criteria will be incorporated in Senior Executive Service performance plans in the first quarter of Fiscal Year (FY) 2020, and guidance issued to Under Secretaries, Assistant Secretaries, and Key Officials by the Assistant Secretary of HRA/OSP to evaluate the performance of supervisors under the same criteria.

Recommendation 16. The Assistant Secretary for Accountability and Whistleblower Protection ensures the implementation of whistleblower disclosure training to all VA employees as required under 38 U.S.C. § 733.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

OAWP has been working with OSC and OIG to collaborate and develop training required for all employees under 38 U.S.C. § 733. This training has been developed at the same time as OAWP continues to improve its operations, including ensuring that investigations are conducted in a timely and thorough manner; establishing a compliance team; and issuing written policy on OAWP investigations.

VA anticipates issuance of the 38 U.S.C. § 733 training, including a specialized module for supervisors, via VA's Talent Management System (TMS) which captures completed training for each employee.

Recommendation 17. The VA Secretary makes certain supervisors' training is implemented as required under § 209 of the VA Accountability and Whistleblower Protection Act of 2017.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions by the end of the calendar year.

VA's Chief Learning Officer is working with OAWP and other organizations to design the training required under § 209 and implement through TMS. TMS will allow VA to assign the training to certain supervisors and monitor compliance with the requirement.

Recommendation 18. The Assistant Secretary for Accountability and Whistleblower Protection confers with the VA Office of General Counsel to develop processes for collecting and tracking justification information related to proposed disciplinary action modifications consistent with 38 U.S.C. § 323(f)(2).

VA Comment: Concur. VA completed the actions required to resolve this recommendation in June 2019.

In June 2019, OAWP implemented an information system to track investigations and recommendations made by the Assistant Secretary. This system will allow OAWP to identify trends, as required by the Act. VA Directive 0500 also requires that Under Secretaries, Assistant Secretaries, and other Key Officials, will in accordance with 38 U.S.C. § 323(f)(2), respond to OAWP recommended actions, including providing a copy of the action taken or proposed and, if the recommended action was not taken or proposed, providing a detailed justification why such an action was not taken or proposed within 60 calendar days of OAWP's recommendation. This information is then relayed to Congress, as required under 38 U.S.C. § 323(f)(2). Data on disciplinary actions impacting pay are maintained in VA's official systems of records for the Department, HRSmart.

Recommendation 19. The VA Secretary in consultation with the Office of General Counsel and the Assistant Secretary for Accountability and Whistleblower Protection ensures compliance with the 60-day reporting requirement in 38 U.S.C. § 323(f)(2) consistent with congressional intent.

VA Comment: Concur. VA completed the actions required to resolve this recommendation in September 2019.

The Secretary fully intends to comply with the Act, including that reporting requirement. This requirement is memorialized in VA Directive 0500, issued on September 10, 2019, which states that Under Secretaries, Assistant Secretaries and other Key Officials will respond to OAWP recommended actions, including providing a copy of the action taken or proposed and, if the recommended action was not taken or proposed, providing a detailed justification why such an action was not taken or proposed within 60 calendar days of OAWP's recommendation. This information is then relayed to Congress, as required under 38 U.S.C. § 323(f)(2).

Recommendation 20. The Assistant Secretary for Accountability and Whistleblower Protection develops or enhances database systems to provide the capability to track all data required by the VA Accountability and Whistleblower Protection Act of 2017.

VA Comment: Concur. VA completed the actions required to resolve this recommendation in June 2019.

In June 2019, OAWP implemented an information system to track investigations and begin to identify trends, as required by the Act. Data on disciplinary actions impacting pay are maintained in VA's official systems of records for the Department, HRSmart, which is managed by HRA/OSP.

Recommendation 21. In consultation with the VA Office of General Counsel, the Assistant Secretary for Accountability and Whistleblower Protection completes the publication of Systems of Records Notices for all systems of records maintained by the Office of Accountability and Whistleblower Protection, and adopts procedures reasonably designed to ensure that the OAWP does not create additional systems of records without complying with the requirements of the Privacy Act of 1974.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

OAWP is consulting with OGC and the Office of Information and Technology (OIT) as it develops and publishes a Systems of Records Notice to cover the information that it obtains and maintains. OAWP will ensure that it does not create additional systems of records without complying with the requirements of the Privacy Act.

Recommendation 22. The Assistant Secretary for Accountability and Whistleblower Protection consults with the VA Chief Freedom of Information Act Officer to ensure adequate training and staffing of the Office of Accountability and Whistleblower Protection's Freedom of Information Act Office, and establishes procedures to comply with FOIA requirements including timeliness.

VA Comment: Concur. VA is taking actions required to resolve this recommendation and anticipates completing these actions before the end of the calendar year.

OAWP is working with OIT to ensure that its Freedom of Information Act (FOIA) staff are properly trained. OAWP FOIA staff are also solely focused on OAWP FOIA matters. OAWP is also developing a FOIA SOP and has leveraged contract FOIA services already established in VA to assist the office with eliminating its FOIA backlog and handling future FOIA requests.

There are 65 pending FOIA requests that OAWP is currently reviewing. OAWP is working expeditiously so that it can eliminate its FOIA backlog before the end of the calendar year.

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