United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

October 29, 2019

The Honorable Robert Wilkie
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary,

We are writing to share our deep concern regarding the Department of Veterans Affairs' (VA) failure to implement the VA Accountability and Whistleblower Protection Act of 2017 (the Act), as documented by the Office of Inspector General's (OIG) October 24 report, as intended by Congress. As Secretary, the oversight and implementation of this law and the proper functioning of the Office of Accountability and Whistleblower Protection (OAWP) falls to you. It is clear from this report that there are significant deficiencies in your office's management of this issue. The sweeping nature of the report's findings cover almost every aspect of OAWP's operations and mandated functions. This is all the more surprising given the high level of publicity the administration has focused on this law and your stated commitment to protecting whistleblowers and ensuring accountability.

Ensuring that whistleblowers have a well-functioning, fair, and reliable system through which they can safely report waste, fraud, and abuse and are protected from retaliation is critical to a high-performing VA. Similarly, the VA workforce and the veterans they serve must be confident that OAWP is holding senior officials accountable consistent with the law and not giving them more lenient treatment.

We will not take the time in this letter to re-state every one of the troubling conclusions in OIG's 91-page report. The report provides some description of steps VA is planning to take to address the 22 OIG recommendations but there are other key issues where additional details are needed.

Secretarial Oversight of OAWP

The Act directs you as Secretary to perform functions related to accountability and whistleblower protection. These are in addition to your normal oversight and management duties. The law contemplated your direct engagement in the office and given the outcome of the OIG's review, we are concerned with how closely you monitored OAWP. During your time as Acting Secretary and since your time as Secretary, what steps did you take to perform oversight of OAWP and ensure the office was effectively meeting its responsibilities as outlined by the law?

Ensuring Due Process in Previous and Future Cases

The OIG report documents numerous concerning practices that OAWP used while handling investigations. These included: not interviewing critical witnesses as part of investigations; an approach to gathering evidence that focused on searching for information to confirm the desired outcome in a case rather than collecting all available evidence surrounding a case and making a determination based on the facts; referring cases within OAWP's jurisdiction outside of the office while taking on cases that were outside OAWP's jurisdiction and expertise; requiring whistleblowers to disclose their identities as a prerequisite to working with OAWP; and providing incomplete evidence files to the VA's Office of General Counsel. These are just a few of the challenges the report documents. Given these problems, what steps is VA taking to review all cases that have previously been handled by OAWP or offices to which OAWP referred them, to ensure that all relevant rules, regulations, and provisions of law were followed in each case? The Department must ensure that these individuals, however belatedly, receive due process for their cases. Regarding new cases, what steps is OAWP taking to ensure due process and quality investigations are being conducted in parallel to the wholesale restructuring and reform that the office requires?

Status of the Individuals Who Previously Led OAWP

The report describes highly questionable and troubling management of OAWP starting when the office was created by Executive Order (EO), continuing to when it was codified by Public Law 115-41 and beyond. This is all the more alarming because these were leaders of an office focused on accountability, trust, and protecting whistleblowers. The OIG report describes a number of concerning incidents including OAWP investigating a whistleblower, at the request of a VA senior leader political appointee who had social ties to the OAWP Executive Director, who had a complaint pending against the same senior leader. After a short investigation, the OAWP substantiated the allegations against the whistleblower without even interviewing him/her. Rather than face the results of this truncated and flawed review process, the whistleblower left VA. In a separate incident, OAWP leadership intervened in one of its own investigations to prevent the direct questioning of the then General Counsel as part of the review. Instead, it required the interview to be conducted via written questions - each of which required OAWP leadership's preapproval.

While we understand that many of the individuals who led OAWP no longer work in OAWP or the VA, we would like to understand the terms under which they left OAWP and what steps were taken to hold them accountable for their performance. Please provide the OAWP employment history, including those who served in an acting capacity, since creation of OAWP through EO to the present for the following positions: Executive Director, Deputy Executive Director, Investigations Director, and Senior Advisor.

Fixing Culture of Fear and Retaliation

Perhaps the most disconcerting aspect of the report is its discussion of the ongoing feeling of fear among whistleblowers, and employees generally, that OAWP, the very office created to ensure they were protected, is a place they will face "retaliation or disciplinary action for reporting suspected wronging." What steps can you take, as the leader of the Department, to rebuild trust with employees and make OAWP an office that they can feel confident coming to for assistance?

Resources to Address the Scope of OAWP's Challenges

The 22 recommendations in the report document a broad scope of changes needed to rebuild OAWP. While it is clear from VA's written responses to the report that some of these steps are underway, we question the feasibility of meeting the articulated deadlines which in many cases are the end of this calendar year or early in 2020. Please provide us with information regarding how VA will ensure those deadlines are met to include the monitoring that your office will perform. In addition, do OAWP and other relevant stakeholders within the VA have the appropriate staffing and budget to accomplish implementing these recommendations in a way that they will have the desired outcome?

Again, we are alarmed by the findings contained in this report and the level of dysfunction that occurred considering it has been nearly two and a half years since the office was established by EO. The functions of this office are too important to the employees that work at VA, and consequently, the veterans they serve, to let them go unaddressed any longer.

We look forward to your response and appreciate your attention to the issues raised in this letter.

Sincerely,

Jon Tester

Patty Murray

Sherrod Brown

Richard Blumenthal

Mazie K. Hirono

Kyrsten Sinema