Mr. Christopher Shea Wilkes
VA Truth Tellers
United States of America
3646 Youree Drive
Shreveport, Louisiana 71105
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The Honorable Senator Johnny Isakson
Chairman of U.S. Senate Veterans Affairs Committee
412 Russell Senate Office Building
Washington, DC 20510

My personal story begins when I returned to the Mental Health Department at the Overton Brooks Veterans Administration Medical Center in December 2011 as the Local Recovery Coordinator (LRC). As the LRC, my job was to consult directly with the Chief of Mental Health to convert all existing programs to and to assure all new programs were operating under the Recovery Model of Care. Thus, my position was considered part of the Mental Health Leadership team.

It was early in my time as LRC that I started to notice questionable practices within Mental Health. The first were hiring practices, treatment of employees and issues with group therapy. It was obvious that certain persons were given special privileges over other employees and that certain employees were targeted by members of leadership. As I began to learn the processes of the VA in more detail, my role expanded. I took on a performance measure responsibility for the service (OEF/OIF Performance Measure), attended director staff meetings, and worked on special projects.

I saw leadership use cronyism in the hiring of a Mental Health Service Chief that had absolutely no experience and was totally incompetent. There were several other applicants with 20+ years of experience, but instead they picked a good ole' boy over the

most qualified. I again watched cronyism rear its head as the hiring process for the Assistant Chief of Mental Health was manipulated. This time I decided to report the situation to Human Resources (HR). After speaking to HR and bringing to their attention possible faulty hiring practices, I was approached by Mental Health leaders and asked to be the acting PTSD Clinic Coordinator.

A day later I was contacted by telephone by a Mental Health leader (Operations Manager) who explained that the permanent PTSD coordinator position would be coming open and it would be a highly competitive position. My response was “really that's cool”. The individual continued asking if I wanted the position. My response was “I'd have to discuss a decision like this one with my wife.” The Operations Manager quickly responded “no don't tell anyone about this”. Mental Health leadership made it very clear that if I would back off the hiring practices of the Assistant Chief of Mental Health, I would be awarded the PTSD Clinic Coordinator position. I was offended by such an offer as I had just turned the service in for faulty hiring practices and now they had the audacity to ask me to do such an unethical act.

Once the leaders of Mental Health learned that I was not going to accept their offer, the first attempt of reprisal came. The Mental Health Chief and Operations Manager went to the Administrative Officer to the Chief of Staff and the Chief of Human Resources and complained that I had lied on a Learning Development Institute application. Luckily, I was able to fight this retaliation attempt off. I had kept cell phone text of conversations between myself and Mental Health leaders that proved that I had not lied on my application. This reprisal attempt quietly went away.

Eventually the incompetent Chief of Mental Health stepped down and the service

went without permanent leadership for an extended period of time. During this time I took on many hats and at one point served as Acting Assistant Chief of Mental Health. I completed projects for the Director, Chief of Staff, and developed key ideas that are still being used in Mental Health today. It was during this time that I started to learn of number manipulation, scheduling manipulation, and other unethical acts. I addressed these acts in Mental Health leadership meetings, with the Chief of Staff, and others, but very little was done to correct the issues.

Early in 2013 a VA Office of Inspector General (OIG) report was released concerning unethical acts at the Atlanta VAMC. At this point I had become totally frustrated with trying to address the corruption through the internal channels of the Overton Brooks VA system. However, I decided to give the Chief of Staff one last chance to address the issues of manipulation of scheduling and numbers.

I reported my concerns one last time to the Deputy Chief of Staff (COS)(acting COS at the time) about hiring practices, manipulation of scheduling, and manipulation of numbers. I was blown off by the Deputy Chief of Staff. It should be noted that later became the permanent COS. After waiting a month, I decided it was time to report the wrongdoings to the VA Office of Inspector General. In June 2013, I made an official VA OIG report related to issues concerning faulty hiring practices (Chief of Mental Health), manipulation of numbers related to performance measures, and scheduling manipulation within Mental Health Service. I never heard one word of response from the VA OIG.

It has now become apparent that the fact that I reported information to the VA OIG June 2013, was relayed back to the facility. Looking back it was from that point forward things began to change for me, not only in Mental Health, but throughout the

hospital.

It turned out that the individual that was selected for the position of Chief of Mental Health was a friend of the Deputy COS. Again, cronyism was evident- the same manipulation of hiring practice that I had reported to the VA OIG. By the fall of 2013 I was being billed as the problem child, trouble maker, and unstable employee. This was for nothing more than telling the truth. I was approached by leaders and told to let unethical acts, such as illegal access to my medical and employment records, go and that I should move forward.

It was apparent that new leadership was not going to address the unethical activity, but rather it would be allowed to continue and those unethical persons would be allowed to continue to hold leadership positions. I would not back down from unethical leaders and I continued to bring up issues and fight to block unethical acts. This infuriated those above me and I became a target.

I was called by the Chief of Mental Health to meet with him in his office. In the meeting, he asked me if I had ever been seen by a particular Mental Health provider in Mental Health Service. I explained I had seen the doctor after returning from Afghanistan. The Chief of Mental Health continued by saying that a colleague had told him I was unstable and unfit to lead. I explained to him that was interesting because I was currently the HHD Commander for a USAR Multi-functional Medical Battalion. I continued by saying that it was obvious that someone had been in my records. The Chief of Mental Health quickly stated that he could not remember who told him about my seeing the particular doctor. I went to the privacy officer after the meeting and obtained a copy of who had been in my record. I found numerous persons that had illegally accessed my

personal information. The hospital conducted an investigation but claimed that they had found nothing.

My fate was sealed in the Mental Health Service when I started questioning compensation time/ overtime issues. Around the end of 2013, I began to suspect fraud related to comp time/overtime. The operations manager, that offered me the PTSD Coordinator Position to shut up about the hiring practices, was constantly disapproving everyone's request for comp time and overtime except for a select few. I started to pay closer attention to this area of discussion in meetings. The issue hit a boiling point when the Operations Manager denied my assistant legitimately earned 3 hours of comp time. The Operations Manager denied the comp time due to her not being there to approve it before it was earned. When I inquired as to why there was no other person that could approve comp time, I was warned by the Chief of Mental Health to let the issue go. I explained that we would take the issue to higher levels if need be to obtain the three hours comp time.

At this point there were too many red flags surrounding the issue for me not to investigate the possible issue more. I later put in a FOIA request (after leaving Mental Health early 2014) for all Mental Health leadership's comp time and overtime earned. I discovered the Operations manager had an extreme number of earned comp time hours and other certain individuals in the service had extremely high hours of paid overtime.

I reported my findings through the VA OIG Hotline and had to argue with the person on the hotline about taking my compliant. At first, I was told by the hotline that this was a facility problem. I insisted that it was possible comp time and overtime fraud and my compliant was ultimately taken by the hotline.

I later learned that the OIG referred my compliant to the Faculty Director for a response. My understanding is that the issue was passed on to Chief of Staff, who in turn had Mental Health Leaders provide a report. In other words, nothing happened.

When speaking with Office of Special Counsel months later, I explained the comp time/overtime issues. The following week I was contacted by VA OIG and told the issues were under investigation. I understand at some point VA OIG was at the facility investigating the issue but I never spoke to them in person. I later sent a FOIA request to the VA OIG for information related to the case but was told the case was still open.

I was systematically removed from Mental Health leadership through a well-organized manipulated hiring process. The Local Recovery Coordinator (LRC) position I held was eliminated and a Recovery Supervisor position was created. The position was an upgrade from GS-12 to GS-13. I had received outstanding and excellent performance evaluations during my time in the LRC Position. Since the position was upgraded, I had to reapply. Once again, I was offered the "hook-up" but, once again, I declined and insisted that the job needed to be announced and the hiring process should be completed properly.

The hiring process was completed and I was by far the most qualified for the position, but was not selected. It was easy to see that the hiring practices had been manipulated through screening tools. At this time I knew that I had to get out of Mental Health as the only positions I was offered were frontline positions under the very people that I had turned in for unethical acts. I knew that, if I stayed, I would face the same horrible retaliation from leaders, that I had witnessed other employees face.

At this point I went through my NFFE Union President to ask the Director for a

transfer out of Mental Health as soon as possible. There was arguing back and forth about the FTE, but the Director stepped in prior to her retirement and ordered Mental Health to give up the FTE to Primary Care so that I could be moved out. In my request, I mentioned that I would like to move to the OEF/OIF Team, but that I had experience in numerous areas.

I was moved to the OEF/OIF Care Team which was located on the 10th floor. My office was located at the opposite end of the 10th floor away from the OEF/OIF Care Team. My office was a large storage room type office with no windows. The hospital air conditioning unit was above the office and made a constant sound of metal grinding. I placed a work order with engineering which informed me there was no real way to stop the grinding sound. When I originally moved into this office I was informed I would only be in office for a month and not to unpack my boxes. That month turned into several months and I sat in the office away from my new team members, packed boxes sitting in the corner. The position created in OEF/OIF was developed to see Veterans but as an extra staff member with no case management load and few referrals, it was difficult to meet the expected numbers.

In April 2014 the story of the wait-list at the Phoenix VAMC surfaced in the media. I had sat in meetings where wait-lists were discussed and had seen wait-lists during my time in Mental Health Department. As mentioned, I had already reported wait-time issues and knew that the scheduling practices were manipulated so that it would make wait-times look better. Bottom line is I knew from my time in leadership that several methods were being used to make the 14 day measure numbers look tremendously better than they were.

After watching the Phoenix VAMC story develop, I decided that I could not wait any longer for VA OIG to take action on my June 2013 complaints. I contemplated what to do next and felt I had exhausted all internal options to report the wrongdoings, so I hesitantly decided to take my story to the media.

I went to the Shreveport Times in May 2014 and worked with a Times Reporter for 2-3 weeks on the story. As the story develop and it was close to being released I was told that TV was probably going to contact me as well as other media sources. I explained that I was not really wanting to speak with a lot of media, but I would be happy to speak with one TV media source as long as the story was focused on Veterans Care issues and not me.

As the time drew closer I feared that once the story was published that the lists in Mental Health would disappear. I also knew once the article ran in the media, my life would change forever, especially my career with the VA. I had seen firsthand how persons who brought issues forward were treated, but I also knew I could no longer look away as Veteran received substandard care.

I decided at this time that I needed to secure a copy of any and every wait-list in Mental Health I could get my hands on. I enquired from Mental Health colleagues I had worked with previously and learned that the numerous list had been joined to form one list. Despite fear of retaliation, with the help of other employees, I was able to obtain a copy of the lists and other evidence of the lists existence.

The Shreveport Times story on the issues at the OBVAMC ran on Sunday June 1, 2014. I met with the TV for an interview on Tuesday June 3, 2014. Around the same time I yet again filed a report with VA OIG that I now had a wait-list in my possession

and that I knew the hospital was manipulating numbers and scheduling throughout the hospital. When the story hit the news, as I anticipated, the list was removed from the share drive and replaced with a different list that was posted and password protected.

I sat patiently and waited for VA OIG response, but received nothing. I watched as the good ole' boy leaders of our facility circled the wagons and started developing their cover-up stories. I was told by my frontline supervisor that her boss, the Chief of Primary Care, had made a visit to her office and was not happy. She explained that he told her that what I did was wrong and that when things were all said and done I would be standing here like the officer in the movie "Bridge Over the River Kwai" stating "What have I done, what have I done". Emails were sent out by the Mental Health Service Chief calling the allegations lies and stating that I was trying to destroy Mental Health.

He began circulating the story that the list was not a secret wait-list but a list to help find Veterans that may have slipped through the cracks. Numerous persons working in Mental Health approached me. They complained that it was as if Mental Health leaders were trying to brainwash them into believing their concocted story. But everyone knew the truth, they knew that the lists were lists of patients who needed appointments.

For over a month the VA was allowed to develop its story and propaganda. The hospital even brought in public relations personal from other facilities and prepared a dog and pony show in which they denied everything. Several Veterans heard the VA's story of what was going on and called the TV station and backed up what I was saying. One Veteran did an interview and explained the exact procedures that were occurring. He

even revealed that he had indeed personally seen the wait-list.

After patiently waiting for VA OIG to come in and investigate I decided I could wait no more because the corrupt good ole' boys continued to cover their tracks. I knew the longer it took investigators to get to the facility the less they would find. I contacted Senator Mary Landrieu who sent a letter to Acting Secretary Sloan Gibson. I also contacted Senator David Vitter's office in an effort to get OIG to OBVAMC. Senator Vitter office sent a letter to the VA OIG Director Richard Griffin demanding that the list be investigated. The next day after the letter was sent I received a call from a VA OIG Special Agent. The agent explained that he and another agent were headed to Shreveport from New Orleans and that they wanted to meet with me. I was excited that finally VA OIG was coming to investigate.

Due to the timing, I originally believed that the OIG's call was in response to the request from Senator Vitter. It appeared that after a year of trying to get the VA OIG's attention, that the existence of the wait-list and other methods of scheduling manipulation were finally going to be investigated.

A few hours after I received the first call from the OIG Special Agents, I received another call from them explaining they had arrived in Shreveport. They explained that they needed the list and asked if I wanted to meet them somewhere off station.
I explained that I did not feel comfortable taking the wait-list off hospital grounds and that one copy of the wait-list was on the computer's hard drive. The OIG Special Agents agreed to meet me in my office on the 10th floor.

When the OIG Special Agents arrived at my office we sat down and I signed a release and we began discussing the issues related to the wait-list and other scheduling

practices used to manipulate performance measure numbers. I showed the agents the wait-list on the hard drive and explained how I got to the list on the share drive. The OIG Special Agents asked about copies of the list and I provided them the two hard copies I had. The agents then took the hard drive from my computer. The agents left telling me they were headed to Mental Health to speak with other employees. I took the rest of the day off to settle my nerves.

The next day the OIG Special Agents came back to speak with me. I signed another waiver and we began to discuss the list again. At this point I realized that their questions were related more towards how I obtained the wait-list and not about why the wait-list existed. I also realized that they were unaware of the request by Senator Vitter or of the recent news article and television interviews.

Later that evening I spoke to a person whose name I had given to the OIG, who explained that OIG Special Agents had explained to her that if she had provided me access to the list that she could be an accomplice to a crime. She explained to my attorney and I that she was trying to get find a lawyer. At this time she also explained to my attorney and I how the list was created and how it was used because there were not enough providers to see everyone. My attorney made some telephone calls and obtained her legal counsel.

My attorney contacted the OIG Special Agents and asked them if I was under criminal investigation. The OIG Special Agents explained to my attorney that they were criminal investigators and that they were investigating the issue of how I obtained the list. My attorney at this time told the OIG Special Agents that all communication should go through him. The damage had already been done.

The OIG had come to Shreveport not to investigate the wait list and other scheduling issues. The OIG had come to perform damage control, intimidate other potential whistleblowers, and to investigate me, the whistleblower. The investigation they conduct was shoddy at best and they only interviewed Mental Health persons that would stand to face discipline if there was a list. They intimidated the other employee whose name I had given them. Her story totally changed from what she had explained to my attorney and I for fear that she would be charged with a crime.

A few weeks later the OIG Special Agents contacted my attorney. They explained they were headed to Shreveport and asked if they could speak to me. My attorney explained to the inspectors that he would let the investigators talk to me about everything except how I obtained the list. The OIG Special Agents met with my attorney at his office. The two agents were accompanied by a polygraph tester. My attorney again reiterated to the OIG Special Agents that he would allow them to speak to me about anything except how I obtained the list. The agents said that they didn't need to talk to me about anything else.

They also told my attorney that there was nothing to the list. My attorney questioned why they had only talked to select persons in Mental Health and not others that wished to talk. The agents then turned to the fact that I had brought up that other scheduling procedures were being used to manipulate the performance measures. The agents asked my attorney for names and I provided my attorney with names of schedulers in other areas of hospitals that had explained to me they were instructed to schedule in such a way that numbers would look better on performance measures.

It was at this point that I became totally discouraged and had to shift focus into a

mode of protecting myself against possible criminal charges instead of advocating for Veterans' care. Over the next several months I experienced the weight of an investigative agency of the federal government. The pressure from having the burden of a criminal investigation hanging over me was tremendous. I was also experiencing pressure from OBVAMC leadership. I became extremely frustrated that neither the OIG nor the VA leaders cared enough about the Veterans' care to do a complete investigation into reported wrongdoings. It was literally heartbreaking for me as an individual who has only wanted to do two things in my life: to be a soldier and to help Veterans. Despite my whistleblowing I continued to witness poor care being provided to Veterans. I had put my career and livelihood on the line and all I gained by doing so was being purposely isolated by the VA and hung out to dry by the OIG.

There is no doubt in my mind the OIG's sole purpose of coming to Shreveport was to intimidate myself and other potential whistleblowers for coming forward. Their main purpose was intimidation and damage control. The investigation was half-assed and shoddy at best. The OIG showed no interest investigating the wrongdoings in the hospital. Rather they interviewed select persons with the intention of intimidating them and others not to come forward with information about how and why the wait-lists existed. I had given the OIG Special Agents the names of numerous witnesses who could substantiate my claims of wrong doing. They did not take the time to interview most of them.

For coming forward and telling the truth I was now in a job way below my ability level. I was asked to complete a training that I explained to my leaders I was ethically unable to complete. I was told I needed to do the training because the COS wanted 100%

compliance. I explained I was not going to complete the training because it placed my integrity in jeopardy. I was given a letter of admonishment for not completing the training. I filed a grievance concerning the letter of admonishment which turned out to be a joke due to the fact that Step 1 went to the Service Chief that was ordered by the COS to discipline me and Step 2 of the process was assigned to the COS who ordered the Chief of Primary care to discipline me. I complained that this was a conflict of interest to no avail. Thus, I withdrew my grievance in order to file with the Office of Special Counsel. After filing a retaliation claim for the letter of admonishment against my supervisor, Chief of Primary Care, and COS things became more tense for me in the OEF/OIF team. My supervisor and I were not getting along so I distanced myself. My supervisor took a position at another facility. Prior to leaving she gave me an unacceptable performance appraisal for not following directions concerning the training and left the next day.

As I languished for a year under investigation for obtaining a list that wasn't supposed to exist I began to contact other whistleblowers. My anger started to increase as it became apparent the OIG had used the same scare tactics all over the country to intimidate other whistleblowers. To make matters worse the OIG began time and time again whitewashing reports and attacking whistleblowers in these same reports. This solidified my belief that the OIG was not going to help solve the problem, but that it in fact was part of the overall problem with the VA System. After living a VA nightmare the last year it has become very apparent and saddens me to say that I see no real change in how VA operates. I believe that the problems with the VA are endemic to its structure. There will be no real reform until there is an independent agency that is willing to

conduct thorough investigations and the system starts hold individuals at every level accountable.

The VA has become a bloated bureaucratic system in which its leadership is more interested in perpetuating their own careers rather than caring for our veterans. When given a performance measure, leaders don't look at how they can adapt their programs to meet the measure, rather they look at the performance measure and try to figure out a way to manipulate it to make it look like they have met the expected goal. The system needs true reform and its leadership needs to be held accountable for its failures.

It is my belief that until we are able to protect whistleblowers and potential whistleblowers the true depth of the corruption within the VA will not be known. The years of cronyism and lack of accountability have allowed least two generations of poor incompetent leaders to plant themselves within the system. These poor leaders have trained other poor leaders and they have isolated the VA from the real world of efficient and effective medical treatment. The VA's continued inability to tell the truth has caused generations of Veterans to lose trust in their services. It is apparent that until the VA is absolutely with no exception forced to change, it will not do so.

Very Respectfully,

Shea Wilkes