



**Testimony of  
Rebecca Jones, Policy Counsel  
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before the House Committee on Veterans Affairs  
Subcommittee on Oversight and Investigations  
On “Learning from Whistleblowers at the Department of Veterans Affairs”  
June 25, 2019**

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to testify today on the vital role of whistleblowers at the Department of Veterans Affairs (VA), and on the steps you can take to protect those brave whistleblowers. I am Rebecca Jones, a Policy Counsel at the Project On Government Oversight. POGO is a nonpartisan independent watchdog that investigates and exposes waste, corruption, abuse of power, and when the government fails to serve the public or silences those who report wrongdoing. We champion reforms to achieve a more effective, ethical, and accountable federal government that safeguards constitutional principles.

**The Role of Whistleblowers at the Department of Veterans Affairs**

Whistleblowers at the Department of Veterans Affairs put their careers on the line every time they speak truth to power to ensure the best care possible for those who put their lives on the line to defend our country. In that way, VA whistleblowers are heroes serving heroes.

Disclosures by VA whistleblowers save patients’ lives by bringing to light barriers to timely and effective medical care due to either negligence or intentional misconduct, exposing officials who have perpetuated a culture of abuse for decades, and freeing up taxpayer dollars that are being misused and that instead can and should go toward providing resources and care.

We’ve seen firsthand the profound and immediate impact whistleblower disclosures can have on quality of care at the VA. Many are familiar, for example, with the wait lists at Arizona’s Phoenix VA Health Care System brought to light by VA whistleblowers. While the system’s computer records falsely indicated that vets were getting timely medical appointments, a secondary and accurate wait list reflected the actual prolonged wait times that veterans were experiencing. That secondary list showed that approximately 1,400 veterans were waiting months to meet with a doctor. At least 40 of those veterans died waiting in the backlog tracked by the accurate list.<sup>1</sup> To add insult to injury, this wait-list scheme didn’t just hide the magnitude of the problem from Congress and the public, it likely ensured that high-level officials received personal performance bonuses.<sup>2</sup> The VA inspector general found in 2014 that the way the VA

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<sup>1</sup> Scott Bronstein, Drew Griffin and Nelli Black, “Phoenix VA officials put on leave after denial of secret wait list,” CNN, May 1, 2014. <http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/>

<sup>2</sup> Chelsea J. Carter, “Were bonuses tied to VA wait times? Here’s what we know,” CNN, May 30, 2014. <https://www.cnn.com/2014/05/30/us/va-bonuses-qa/>

cooked the books made it seem that the system operated efficiently. Taking advantage of this appearance, “leadership significantly understated the time new patients waited for their primary care appointment in their [leadership’s] FY 2013 performance appraisal accomplishments, which is one of the factors considered for awards and salary increases,”<sup>3</sup> according to the inspector general.

Unfortunately, the misconduct in Phoenix was not an isolated incident. Complaints of inaccurate VA wait lists can be traced back over a decade and all over the country,<sup>4</sup> and even after the Phoenix scandal, the abuse persisted. And whistleblowers continued to be essential in bringing those abuses to light.

For instance, in 2015 the VA inspector general released a report in response to this committee’s request to investigate a whistleblower’s disclosure of mismanagement at the Veterans Health Administration’s Health Eligibility Center.<sup>5</sup> The inspector general substantiated many of the whistleblower’s disclosures, finding that the Chief Business Office, the central authority for determining VA benefits eligibility and enrollment, had “not effectively managed its business processes to ensure the consistent creation and maintenance of essential data.”<sup>6</sup> That mismanagement included deleting 10,000 or more unprocessed applications, and employees hiding applications in their desks. The IG noted that in the instance of employees intentionally hiding applications, the VA neither reported the incident to the VA inspector general, nor did it discipline the employees responsible because leadership had played a part in the situation.<sup>7</sup>

In 2017, two whistleblowers disclosed that a secret wait list in Omaha hid the fact that 87 veterans faced inordinate delays for mental health appointments. Congressional attention and pushback helped to highlight this incident, but no employees were terminated from employment.<sup>8</sup>

And just this month, a whistleblower came forward alleging that, yet again, VA facilities are secretly keeping separate, miles-long wait lists—three times the size of the public lists—to conceal long delays in care. As you know, this committee and its counterpart in the Senate sent a

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<sup>3</sup> Department of Veterans Affairs Office of Inspector General, *Veterans Health Administration - Interim Report - Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*, May 28, 2014. <https://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf>

<sup>4</sup> Rich Gardella and Talesha Reynolds, “Memos Show VA Staffers Have Been ‘Gaming System’ for Six Years,” *NBC News*, May 13, 2014. <https://www.nbcnews.com/storyline/va-hospital-scandal/memos-show-va-staffers-have-been-gaming-system-six-years-n104621>

<sup>5</sup> Department of Veterans Affairs Office of Inspector General, *Veterans Health Administration, Review of Alleged Mismanagement at the Health Eligibility Center*, September 2, 2015. <https://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf> (Hereinafter, IG Report)

<sup>6</sup> IG Report, p. ii.

<sup>7</sup> IG Report, pp. 14, 17.

<sup>8</sup> Steve Liewer, “Nebraska-Western Iowa VA kept secret waiting list for some mental health appointments,” *The World Herald*, October 16, 2017. [https://www.omaha.com/news/military/nebraska-western-iowa-va-kept-secret-waiting-list-for-some/article\\_c428a382-320c-560d-bbee-eb0a40ee6b23.html](https://www.omaha.com/news/military/nebraska-western-iowa-va-kept-secret-waiting-list-for-some/article_c428a382-320c-560d-bbee-eb0a40ee6b23.html); Steve Liewer and Joseph Morton, “Secret waitlist delayed care for 87 veterans at VA hospital in Omaha, led to departure of 2 employees,” *The World Herald*, October 31, 2017. [https://www.omaha.com/livewell/nebraska/health/secret-waitlist-delayed-care-for-veterans-at-va-hospital-in/article\\_5048df5a-bb65-11e7-932b-af5b8746deef.html](https://www.omaha.com/livewell/nebraska/health/secret-waitlist-delayed-care-for-veterans-at-va-hospital-in/article_5048df5a-bb65-11e7-932b-af5b8746deef.html)

letter to the VA seeking an explanation.<sup>9</sup> Now, the whistleblower who exposed the wait list is claiming that he is being retaliated against professionally for his disclosure.<sup>10</sup>

In all these instances, it took whistleblower disclosures for the public to learn what happened—a nearly universal truth across the federal government.

And yet, across the federal government, blowing the whistle continues to be a risky business: Even though federal employees are legally protected for exposing wrongdoing, they're likely to face retaliation for doing so. A 2010 survey revealed that about one-third of federal employee whistleblowers say they experience “threats or acts of reprisal, or both.”<sup>11</sup> And potential whistleblowers are discouraged from making disclosures at every turn, whether directly by their supervisor or indirectly by seeing their co-workers retaliated against for speaking out for what's right. All the while, retaliating supervisors go unpunished, or worse—get rewarded. The adage that no good deed goes unpunished is profoundly true for VA whistleblowers.

In 2014, POGO investigated problems at the VA by inviting VA whistleblowers to make secure disclosures to us online. Working with the Iraq and Afghanistan Veterans of America, we received disclosures from approximately 800 VA employees, contractors, and veterans in just a month's time. The disclosures were diverse in both the problems they exposed and the employees making them. Disclosures ranged from a pharmacy technician who faced retaliation for repeatedly reporting missed, late, and expired doses of medication administered to patients, to a nurse being forced out of her job after speaking up for her patients whose injuries were being severely neglected.<sup>12</sup>

In reviewing the disclosures, the theme was clear: VA whistleblowers were terrified of speaking out for fear of losing their livelihood. “Management is extremely good at keeping things quiet and employees are very afraid to come forward,” one whistleblower explained.<sup>13</sup> Worse, not only were whistleblowers being attacked by their employer, the VA inspector general investigating their disclosures or retaliation claims was often worsening the situation by exposing the whistleblowers' identities. POGO soon experienced this toxic culture for ourselves, as the

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<sup>9</sup> Letter from Chairman Mark Takano of the House Committee on Veterans' Affairs, and Ranking Member Jon Tester of the Senate Committee on Veterans' Affairs to Robert Wilkie, Secretary of the U.S. Department of Veterans Affairs, on veterans' access to timely healthcare, June 4, 2019. <https://www.dropbox.com/s/4gcsnmq3d8aq9qe/2019.6.4%20Takano%20and%20Tester%20Wait%20Times%20Letter.pdf?dl=0>

<sup>10</sup> Joe Davidson, “Does VA have a secret wait list for health care? Key members of Congress want to know,” *The Washington Post*, June 5, 2019. [https://www.washingtonpost.com/politics/does-va-have-a-secret-wait-list-for-health-care-key-members-of-congress-want-to-know/2019/06/04/28d149e2-8717-11e9-a491-25df61c78dc4\\_story.html](https://www.washingtonpost.com/politics/does-va-have-a-secret-wait-list-for-health-care-key-members-of-congress-want-to-know/2019/06/04/28d149e2-8717-11e9-a491-25df61c78dc4_story.html)

<sup>11</sup> Merit Systems Protection Board, *Blowing the Whistle: Barriers to Federal Employees Making Disclosures*, November 2011, p. i. <https://www.mspb.gov/mspbsearch/viewdocs.aspx?docnumber=662503&version=664475&application=ACROBAT>

<sup>12</sup> Testimony of Lydia Dennett, Project On Government Oversight, before the Senate Committee on Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, November 6, 2015, pp. 1-2. <https://www.appropriations.senate.gov/imo/media/doc/110615-Dennett-Testimony1.pdf> (Hereinafter Dennett Testimony)

<sup>13</sup> Dennett Testimony, p. 3.

then-acting VA inspector general, Richard Griffin, attempted, unsuccessfully, to force us to hand over the database of VA whistleblower complaints we'd compiled.<sup>14</sup>

In 2018, after a change in inspector general leadership, then-acting VA secretary Peter O'Rourke tried to intimidate the VA's newly Senate-confirmed inspector general, Michael J. Missal, in an attempt to kill an inspector general investigation.<sup>15</sup> Missal raised the alarm when his office wasn't getting requested information and documentation from the agency about the Office of Accountability and Whistleblower Protection—documents that the inspector general is entitled to under the Inspector General Act.<sup>16</sup> In what seemed like a desperate attempt to get the inspector general off his back, the acting secretary wrote, "You are reminded that OIG [Office of Inspector General] is loosely tethered to VA and in your specific case as the VA Inspector General, I am your immediate supervisor. You are directed to act accordingly."<sup>17</sup> Of course, the idea of an inspector general being subservient to an agency head is wholly contrary to both the spirit and the design of federal inspectors general. Nonetheless, the VA apparently felt entitled to lash out against the independent investigation.

Thanks to this committee's leadership<sup>18</sup> and that of its counterpart in the Senate,<sup>19</sup> the backlash against O'Rourke was swift and bipartisan. But the lesson is clear: The modus operandi at the VA, starting at the top of the agency, is to quash investigations and dissent by bullying investigators and retaliating against whistleblowers—all to the detriment of veterans and taxpayers.

## **The Office of Accountability and Whistleblower Protection**

In April 2017, the Office of Accountability and Whistleblower Protection (OAWP) was created through Executive Order 13793,<sup>20</sup> which was later codified and expanded upon by Congress when the VA Accountability and Whistleblower Protection Act was passed into law.<sup>21</sup>

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<sup>14</sup> Letter from Richard Griffin, then-Acting Inspector General, Department of Veterans Affairs, to Project On Government Oversight, regarding subpoena to POGO, May 30, 2014.

<sup>15</sup> Joe Davidson, "As inspectors general are celebrated, VA tried to intimidate its IG," *The Washington Post*, July 10, 2018. <https://www.washingtonpost.com/news/powerpost/wp/2018/07/10/inspectors-general-are-celebrated-as-va-tried-to-intimidate-its-ig/> (Hereinafter, IG Intimidation)

<sup>16</sup> The Inspector General Empowerment Act of 2016 added clear access to agency records for inspectors general. Public Law 114-317, Sec. 5. <https://www.congress.gov/114/plaws/publ317/PLAW-114publ317.pdf>

<sup>17</sup> Letter from Peter O'Rourke, Acting Secretary of Veterans Affairs, to Michael Missal, Inspector General, U.S. Department of Veterans Affairs, about access to documents concerning the Office of Accountability and Whistleblower Protection, p. 2. <https://assets.documentcloud.org/documents/4529198/Letters-Between-Missal-and-O-Rourke.pdf>

<sup>18</sup> House Committee on Veterans Affairs, "RM Walz Responds To Unprecedented Attack By Acting VA Secretary O'Rourke On VA Inspector General," June 18, 2018. <https://veterans.house.gov/news/press-releases/rm-walz-responds-unprecedented-attack-acting-va-secretary-o-rourke-va-inspector>

<sup>19</sup> IG Intimidation

<sup>20</sup> Executive Order 13793, "Improving Accountability and Whistleblower Protection at the Department of Veterans Affairs," April 27, 2019. <https://www.federalregister.gov/documents/2017/05/02/2017-08990/improving-accountability-and-whistleblower-protection-at-the-department-of-veterans-affairs>

<sup>21</sup> Public Law 115-41, Codified at 38 U.S.C. § 323.

A merging of VA's Office of Accountability Review and the Central Whistleblower Office, the OAWP is an internal fact-finding body that:

serves to improve the performance and accountability of VA senior executives and employees through thorough, timely, and unbiased investigation of all allegations and concerns. Where these actions are found factually true, OAWP will provide recommended actions related to the Senior Executive or other senior leader's removal, demotion or suspension based on poor performance and/or misconduct. Additionally, OAWP provides protection of valued VA whistleblowers against retaliation for their disclosures under the whistleblower protection provisions of 38 U.S.C. section 714.<sup>22</sup>

The office is broken into six sub-offices:

- Executive Office of the Director, the overseer and liaison between OAWP and VA leadership;
- Triage Division, the first point of contact for whistleblowers both in making initial disclosures and in reporting retaliation, and the overall case manager that sends intake to different offices, depending on content;
- Investigations Division, the office that conducts investigations into whistleblower retaliation and senior official misconduct allegations when referred to them by the Triage division;
- Advisory and Analysis Division, which recommends corrective action to senior VA leadership based on OAWP investigations, and trains VA leadership on the Accountability Act;
- Knowledge Management Operations, which maintains and creates structural databases for OAWP's work, and;
- Human Resources and Office Support, which provides support to OAWP staff, and conducts external affairs.

As of last year, OAWP was supported by 73 employees.<sup>23</sup>

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<sup>22</sup> Department of Veterans Affairs 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*, June 2018, p. 3.

<http://federalnewsnetwork.com/wp-content/uploads/2018/07/ANNUAL-REPORT-Office-of-Accountability-and-Whistleblower-Protections-Activities.pdf> (Hereafter, OAWP Report)

<sup>23</sup> OAWP Report, p. 6.

In order to be resolved, all VA whistleblowing disclosures must now go through OAWP at some point. Even those that an employee files with the Office of Special Counsel or the VA inspector general must eventually go through the Triage Division for processing.<sup>24</sup>

While the office has now been in operation for about two years, there is very little evidence to indicate that it's functioning as intended. In June 2018, the OAWP released its first annual self-assessment report, as required by statute. While it's clear from the report that the office was still being stood up, it nevertheless saw a predictably huge amount of intake, reporting having received "nearly 2,000 submissions" from whistleblowers in its first year.<sup>25</sup>

Unfortunately, despite the office's mission, that large intake does not seem to have translated into any significant trend of disciplinary actions against senior VA officials found to have retaliated against VA whistleblowers. From OAWP's own reporting, senior executives and senior leadership made up only 0.1% of disciplinary actions taken during OAWP's tenure. That 0.1% maintains the average levels seen since 2014 and, in fact, is actually a decrease from recent years. The total number of disciplinary actions taken from June 2015 to June 2016, for example, was 15 cases, and from June 2016 to June 2017 there were just 9. In OAWP's first year, June 2017 to June 2018, there were only 7.<sup>26</sup>

Instead, during OAWP's existence, 36.4% of disciplinary actions were taken against GS rank 1 through GS rank 6 employees.<sup>27</sup> Based on that reporting, it's difficult to conclude that OAWP is succeeding in its mission of holding VA senior executives accountable for their actions. It reads, instead, like they're maintaining the status quo of focusing disciplinary action on lower level employees.

The Government Accountability Office (GAO) released a review in July 2018 of the VA's employee misconduct procedures and practices, and provided more insight into what is causing this imbalance.<sup>28</sup>

The GAO reported that senior officials engaging in misconduct are not being consistently held accountable at the VA. When a retaliation claim was substantiated and investigators proposed disciplinary action, the VA didn't always follow through with that recommendation. GAO found that the VA failed to discipline senior officials in 5 out of the 17 cases with substantiated misconduct.<sup>29</sup> Information from OAWP seems to explain why: The agency's own attorney is pre-reviewing disciplinary decisions before they're finalized.<sup>30</sup> Such a review indicates that the agency's attorneys could reject proposed disciplinary action, and it risks exposing the identity of the whistleblower to senior agency executives.

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<sup>24</sup> OAWP Report, p. 8.

<sup>25</sup> OAWP Report, p. 9.

<sup>26</sup> OAWP Report, pp. 27-28.

<sup>27</sup> OAWP Report, p. 30.

<sup>28</sup> Government Accountability Office, *Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability*, July 2018. <https://www.gao.gov/assets/700/693268.pdf> (Hereafter, GAO Report)

<sup>29</sup> GAO Report, introduction.

<sup>30</sup> GAO Report, p. 94.

Although OAWP's authorizing statute rightfully forbids the Office of General Counsel's (OGC) involvement in whistleblower claims,<sup>31</sup> OGC is nevertheless heavily involved. Once OAWP's advisory and analysis division completes their disciplinary proposal based on the underlying investigation, they send that proposal to the OGC's office for legal review.<sup>32</sup> Although the OAWP and the OGC are both housed within the VA, their interests are not the same. The OGC's mandate is to represent the best the interests of its client: the VA. Repeated disciplinary actions taken against VA senior officials is not in the VA's best interests. It could affect public perception of the VA's work, future funding, and individual jobs. The OAWP, on the other hand, is in charge of fact-finding and analysis independent of any ulterior motivation to keep the agency out of legal trouble. Allowing agency attorneys to provide legal analysis or review of a proposed disciplinary action is akin to a judge allowing the defense attorney in a criminal case to overturn the judge's decision against a defendant. It's highly unethical for OGC to weigh in on a whistleblower retaliation complaint, because OGC's sole interest is the legal representation of the agency.

GAO also found that employees who stand accused of whistleblower retaliation are reviewing, and sometimes even participating in, their own misconduct investigation due to the VA's systematically weak internal controls to monitor who is involved in an investigation and lax enforcement of the controls that do exist.<sup>33</sup> This practice leads, according to the GAO, to confusion about the role of OAWP and about the office's responsibilities, and could make whistleblowers feel "uncomfortable or intimidated."<sup>34</sup> GAO found instances, for example, where managers "investigated themselves for misconduct." Further, the GAO explains in its report, the VA lacks the oversight measures necessary to ensure that misconduct allegations are investigated by an entity separate from the control or influence of the office accused of misconduct.<sup>35</sup>

GAO also found that VA officials were not following separation-of-duty policies. Such policies require that a final decision on disciplinary action against an individual found to have engaged in whistleblower reprisal be made by an official at least one rank higher than the individual or team who proposed the discipline. This is to ensure multiple levels of review and to preempt any undue influence that someone charged with misconduct might have on the individual or office proposing the discipline. Unfortunately, GAO's report indicates that this is not happening consistently at the VA. Instead, the individuals recommending whether officials should be punished or not were also the individuals deciding whether or not to implement that recommendation. GAO found that 73 VA officials "acted as both the proposing and deciding official" in cases involving removal for employees who engaged in misconduct. GAO followed up on 29 cases of VA officials who violated a separation of duty policy at least twice, and not a single one had been disciplined.<sup>36</sup>

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<sup>31</sup> The VA Accountability and Whistleblower Protection Act of 2017 § 323(e): The Office 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. <https://www.congress.gov/115/plaws/publ41/PLAW-115publ41.pdf>

<sup>32</sup> GAO Report, p. 94

<sup>33</sup> GAO Report, introduction.

<sup>34</sup> GAO Report, p. 55.

<sup>35</sup> GAO Report, introduction.

<sup>36</sup> GAO Report, pp. 44-45.

GAO's report, combined with OAWP's own first-year numbers, do not paint a promising picture of solving the whistleblower retaliation problem within the VA. OAWP's existence hasn't led to greater accountability of senior officials, and hasn't led to greater safety for VA whistleblowers when they disclose abuse.

## **Fixing a Culture of Retaliation**

The problems uncovered by the GAO that relate to OAWP are consistent with what we have seen in other attempts to internalize whistleblower investigations within an agency. This is why POGO recommended increased structural independence for the office in previous Congressional testimony.<sup>37</sup> The OAWP is fighting an uphill battle because it is trying to solve individual claims while simultaneously combating a persistent culture of whistleblower retaliation from within the agency itself. And this concept of a retaliatory culture is no mere speculation: The GAO found that VA whistleblowers are "10 times more likely than their peers to receive disciplinary action within a year of reporting misconduct."<sup>38</sup>

Instead of changing the culture of whistleblower retaliation, keeping investigations under the wing of the larger agency creates an internal clearinghouse used to silence employees speaking out.<sup>39</sup> According to recent reports from VA whistleblowers, several individuals who have contacted the office have had their identities exposed. As a result, the VA inspector general is currently conducting its own investigation into this issue.<sup>40</sup>

The VA's stated vision is to "to provide veterans the world-class benefits and services they have earned—and to do so by adhering to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship." Based on the information available, it's hard to draw any conclusion other than that the agency is failing to make this vision a reality and has been for some time. While OAWP may have been created out of a desire to shift the retaliatory culture, it lacks the structural independence it needs from an agency stymied by a pervasive internal culture of whistleblower retaliation, so the cards were stacked against it from the outset.

## **Recommendations for Reform**

Changing the culture of whistleblower intimidation and retaliation at the VA isn't an easy lift, but it would surely have profound impacts for the veterans who rely on the VA's care. Holding senior officials accountable for their actions is vital for lasting change. It is also essential that the

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<sup>37</sup> Liz Hempowicz, "POGO Testimony on VA Accountability and Whistleblower Protection Act," May 17, 2017. <https://www.pogo.org/testimony/2017/05/pogo-testimony-on-va-accountability-and-whistleblower-protection-act/>

<sup>38</sup> U.S. Government Accountability Office, Fast Facts on "Department Of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability," <https://www.gao.gov/products/GAO-18-137>

<sup>39</sup> Daniel Van Schooten, "POGO and Others Oppose 'Trojan Horse' Office for VA Whistleblowers," September 30, 2016. <https://www.pogo.org/analysis/2016/09/pogo-and-others-oppose-trojan-horse-office-for-va-whistleblowers/>

<sup>40</sup> Eric Katz, "New Whistleblower Protection Office Is Under Investigation for Retaliating Against Whistleblowers," *Government Executive*, April 16, 2019. <https://www.govexec.com/oversight/2019/04/new-whistleblower-protection-office-under-investigation-retaliating-against-whistleblowers/156314/>

agency work to prevent retaliation in the first place by ensuring independent, comprehensive, and swift investigations, and providing quality training for employees on their rights. In doing that, the VA will demonstrate that they take whistleblower allegations seriously and will show employees that it's safe to come forward.

The first step toward improving the functionality of OAWP is ensuring that the office has the independence necessary to analyze and thoroughly investigate both whistleblower retaliation complaints and allegations of misconduct by senior officials. While the best course of action would be to remove OAWP's investigative functions from within the agency's structure entirely, we understand that such a sweeping reform may be a longer-term goal.

To immediately make the office more independent, Congress should mandate that the OAWP have its own office of legal counsel, circumventing any need to refer matters to the VA's Office of General Counsel. OAWP concurs with this recommendation, noting that relying on the OGC creates the appearance of a conflict and creates delays in resolving cases.<sup>41</sup>

To further increase independence, Congress should consider mandating more guidance and oversight from the U.S. Office of Special Counsel (OSC) and OAWP. Such guidance and oversight should include OSC review of OAWP's final recommendations for disciplinary action of senior-official misconduct as a means of quality control. This will also end reliance on agency officials, such as those in the agency's Office of General Counsel, who should be conflicted out of reviewing OAWP decisions.

Congress should mandate that OAWP develop and oversee a comprehensive and transparent system to ensure that those who are the subject of an investigation, and their immediate office, are not able to influence the investigation into their own behavior. Such a system must also ensure that separation of duty policies are upheld in practice. Individuals found to have knowingly and willfully violated these policies should face mandatory disciplinary action. As a part of this, OAWP should better track department-wide disciplinary action, so that they can follow up on whether senior officials are actually being disciplined, while ensuring the protection of the whistleblower involved.

Further, OAWP should implement robust, updated training regarding the options available to employees for reporting disclosures or whistleblower reprisal, the connection between OAWP and other investigative entities such as the U.S. Office of Special Counsel and the VA Office of Inspector General, and the rights of whistleblowers to make disclosures anonymously, as well as training on how a whistleblower's information is to be shared between investigative entities. At the time of OAWP's first report, they had yet to disseminate updated training materials.<sup>42</sup>

Congress should also consider broader reforms to the Whistleblower Protection Act to address issues that plague not just VA whistleblowers, but all federal employees who can claim protection from retaliation under the law. First, Congress should amend the law to include retaliatory investigations as a "prohibited personnel practice" in order to combat one of the most common forms of whistleblower retaliation used to intimidate and stifle those who speak out.

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<sup>41</sup> OAWP Report, p. 22.

<sup>42</sup> OAWP Report, pp. 20-21.

While the Whistleblower Protection Enhancement Act expanded protections for federal employees in 2012, employers responded to the stricter law by opening retaliatory investigations as a means to distract from the underlying disclosure without technically committing an actionable offense.<sup>43</sup> By reforming the law to include these investigations as a prohibited practice, whistleblowers would be protected from the outset of the retaliation, rather than having to wait for suspension or termination from their job.

Second, Congress should extend the right to a federal jury trial to federal employees who blow the whistle. Given prolonged delays in access to justice for whistleblowers who have been retaliated against, federal jury trials would ensure an expeditious, independent forum for whistleblowers to seek relief.

VA whistleblowers blow the whistle because they're honor bound to speak up when they witness violations of the country's trust or individual suffering caused by negligence or corruption. Creating or empowering independent oversight bodies that help whistleblowers make disclosures benefits us all, but it's vital that Congress be willing to quickly amend laws that carry unintended consequences for those they were meant to protect. POGO thanks this subcommittee for taking the next steps in investigating protections and processes at the VA for whistleblowers and we urge you to take action to expeditiously fix this broken system.

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<sup>43</sup> Government Accountability Project, "Ban the Criminalization of Whistleblowers!"  
<https://www.whistleblower.org/truthjailing/>