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IMPROVING VA ACCOUNTABILITY: EXAMINING FIRST-HAND ACCOUNTS OF DEPARTMENT OF VETERANS AFFAIRS WHISTLEBLOWERS

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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TUESDAY, SEPTEMBER 22, 2015

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IMPROVING VA ACCOUNTABILITY: EXAMINING FIRSTHAND ACCOUNTS OF DEPARTMENT OF VETERANS AFFAIRS WHISTLEBLOWERS

TUESDAY, SEPTEMBER 22, 2015

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:34 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Johnson, McCain, Ayotte, Ernst, Carper, McCaskill, Tester, Baldwin, and Peters.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Chairman JOHNSON. Good morning. This hearing will come to order. I want to welcome certainly our witnesses. Thank you for your thoughtful testimony.

I am going to keep my opening statement very short because we have a lot of witnesses, two panels. I also want to make sure that the Committee Members understand we are going to keep questioning to 5 minutes as well—unless we have very few Senators, and then we might open it up again. But it sounds like we are going to have some pretty good attendance.

I do ask that my written opening statement, be entered into the record,[1] without objection.

As I read the whistleblower testimony as well as the testimony from representatives from the Department of Veterans Affairs (VA) and the agencies, and as we have held these whistleblower hearings, the question I have—coming from the private sector where, literally, I would be hanging a medal on individuals in my organization that would go through the layers of management to let me know what was happening on the shop floor, it is extremely difficult when you are the top of an organization to get that real information. Those people ought to be rewarded, not retaliated against. And the question that I will be asking everybody is: Why is retaliation so rampant within the Federal Government? We are focusing on the VA and the VA health care system here, but it is not isolated to the VA. And what is amazing to me is it seems pretty simple, pretty easy, unfortunately, for mid-level managers, within

[1] The prepared statement of Senator Johnson appears in the Appendix on page 61.

these agencies and the Department to retaliate and terminate whistleblowers, but then it is enormously difficult apparently for department heads, Secretaries, top-level management to hold those people that retaliate against whistleblowers accountable, much less potentially even terminate them.

So, that is the problem, and from my standpoint, having run organizations, there is nothing more corrosive to an organization than when individuals within that organization get away with mismanagement, retaliation, and they are not held accountable. Nothing more corrosive. And we have a real problem with the VA health care system, problems that we all want to see fixed, and to me this is in many respects at the heart of those problems. If we cannot hold individuals in the VA health care system and, quite honestly, any manager within the Federal Government accountable, we are going to continue to have problems within all these agencies.

So I do want to point out, because it also is somewhat baffling, we have had on the books whistleblower protection laws for decades. The first whistleblower protection legislation really was the Lloyd-La Follette Act of 1912, followed by the Civil Service Reform Act of 1978, followed by the Whistleblower Protection Act of 1989, followed by the Whistleblower Protection Enhancement Act of 2012. So this is a protection that has been well known for decades, really more than a century, and yet we still see retaliation against whistleblowers rampant within the Federal Government.

So, the purpose of this hearing is to lay these issues on the table with some anecdotal stories here, some pretty powerful ones, to talk to the people in the agencies, and in good faith try and figure out a way to actually provide the whistleblower protection that will actually work so that we can get government to work more efficiently and effectively.

One last thing I want to point out is that within our Senate office, because we value whistleblowers, they are essential, we have set up a website, and I want everybody to understand in the Federal Government you can come to our office by using whistleblower@ronjohnson.senate.gov. I encourage whistleblowers, if you feel uncomfortable talking to your Office of Inspector General, if you feel uncomfortable talking to your direct supervisor about these things, come to our Committee, and we will certainly hear your story and will offer whatever protection we certainly can.

With that, our Ranking Member is going to be a little bit late. We will let him offer an opening statement when he gets here, probably between the panels. But it is the tradition of this Committee to swear in witnesses, so if you will all rise and raise your right hand. Do you swear that the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. KIRKPATRICK. I do.

Mr. COLEMAN. I do.

Mr. COLON. I do.

Mr. WILKES. I do.

Chairman JOHNSON. Thank you. Please be seated.

Our first witness will be Sean Kirkpatrick. Mr. Kirkpatrick is testifying today on behalf of his late brother, Dr. Christopher Kirkpatrick. Dr. Kirkpatrick was a psychologist at the VA Medical Cen-

ter in Tomah, Wisconsin, who raised concerns about patient overmedication. On the day of his termination, Dr. Kirkpatrick tragically committed suicide. Sean is joined in the audience this morning by his sister, Kathryn. Mr. Kirkpatrick.

TESTIMONY OF SEAN KIRKPATRICK,[1] CHICAGO, ILLINOIS

Mr. KIRKPATRICK. Thank you. My family would like to thank the U.S. Senate Committee on Homeland Security and Governmental Affairs for holding this hearing.

It is an honor to be invited here to speak on behalf of my late brother, Dr. Christopher Kirkpatrick. On July 14, 2009, hours after being fired from the Tomah VA Medical Center, Chris committed suicide. Our family found out the next day that he was fired from the Tomah VA the morning he died. The reason they told us they fired him was for missing too many hours.

Last winter, my family learned what really happened to Chris. Ryan Honl, a brave VA whistleblower and former Tomah VA employee, reached out to my family after he heard my brother's story from Lin Ellinghuysen, president of the American Federation of Government Employees (AFGE) in Tomah. Ryan put me in touch with Lin, who provided my family with documentation which proved Chris had raised concerns about possible overmedications and other issues affecting his patients while he was employed at the Tomah VA. If not for Ryan and Lin, my family would have no idea what the truth was behind the circumstances leading to his suicide.

Chris was having difficulty treating patients in the post traumatic stress disorder (PTSD) and substance abuse programs he oversaw because they were unable to alert and engage in therapy due apparently to the high level and type of medications they were prescribed. Apparently, Chris had learned a physician's assistant had complained to the chief of staff, Dr. David Houlihan, that my brother was inappropriate in discussing medications that patients they both see are prescribed.

In an email to his union representative written on April 23, 2009, Chris addressed his concern that he was now in the cross hairs of the chief of staff for suggesting that patients may be overmedicated. He stated, "I have had words with the physician's assistant about medications and possible side effect/adverse reactions patients were experiencing, but these conversations happened months ago. These situations put me in an ethical dilemma. Why this comes up as an issue now is open to interpretation. Based on what others have told me, I have every reason to be very afraid of Dr. Houlihan. I have sacrificed a lot to move up here and do the kind of work I excel at and help people. I need help."

Chris was subsequently reprimanded by his supervisor at the order of Chief of Staff Houlihan in the form of a written counseling on April 30, 2009. One of the points he made in the written counseling was that Chris should not be "educating patients about what medications they are on, and that he should avoid advising on medications altogether." It is evident that those in charge were more concerned about disciplining my brother for questioning medi-

[1] The prepared statement of Mr. Kirkpatrick appears in the Appendix on page 65.

cation practices rather than properly investigating the problem of overmedicated patients.

On July 14, 2009, 10 months after he was hired, Chris was directed to report to the human resources (HR) office. Chris' employment at the Tomah VA Medical Center was terminated during this meeting. Chris was told his services were no longer needed due to performance issues. Several frivolous allegations were made, all of which had no bearing. Chris stated, "I know why this is happening. It is because of the note I put in the patient's chart. He was difficult and violent. He did not belong in this program. He stood at my office door and told me that he intended to do harm to me and my dog. I told you about this. The team decided this patient needed to be discharged and released from the program. On Thursday, July 9, he was still here. I charted this."

Please note that Chris took a vacation day on Friday, July 10, and used a sick day on Monday, July 13, because that threatening patient was not discharged and still there. Chris was terminated that Tuesday, July 14.

He was a recent graduate psychologist studying for his license with a full patient load, facilitating the group therapies on his own, hearing in great detail about horrific events experienced by his patients, but yet he had no guidance and support, despite going through the proper chain of command for assistance more than once. His life's goal of helping our Nation's veterans battle PTSD through innovative psychotherapy techniques was jeopardized because he questioned dangerous medication practices. He did what was ethical and right, but was only met with retaliation.

My family began to have hope that Chris, would be vindicated after all these years since it seemed that the VA was now taking a serious look at the many cases of retaliation against Tomah staff and the dangerously high number of medications being prescribed to the veterans there. However, the Office of Inspector General (OIG) white paper report released this past June was nothing but slanderous toward my brother and insulting to my family. It suggested that he was a drug dealer and it did not take his death seriously. Apparently, the VA is still retaliating against Chris even to this day. For my parents to have to read this public document after everything they have been through is outrageous and unconscionable.

Chris acted in the interests of the veterans at his own expense when he raised concerns about the overmedication of VA patients. His life was threatened by a hostile patient, and his superiors did not discharge the patient after he was told they would. His pleas for support and help managing the complex cases he had were never acted upon. Knowing this now leaves my family with the belief that the VA failed Chris. Furthermore, we learned that the VA never even did an investigation into the suicide of one of its psychologists.

The last thing that Chris said to Lin as she walked him to his car after he was fired was, "Try to get a support system so that no one else has to go through what I did! Will you please do that?"

We are asking the same thing of this Committee. Thank you.

Chairman JOHNSON. Thank you, Mr. Kirkpatrick.

Our next witness is Brandon Coleman. Mr. Coleman is a Marine Corps veteran and addiction therapist at the Phoenix VA Healthcare System. Mr. Coleman raised concerns about improper care for suicidal veterans. Mr. Coleman.

TESTIMONY OF BRANDON W. COLEMAN, SR., PH.D.[1] (c), LISAC, ADDICTION THERAPIST, PHOENIX VA HEALTH CARE SYSTEM, PHOENIX, ARIZONA

Mr. COLEMAN. Thank you, Mr. Chairman. VA whistleblowers risk the destruction of their careers for simply telling the truth. During my time at the Phoenix VA, I have lost six veterans to suicide. Each one is like a punch in the gut. I have walked suicidal veterans to the Phoenix VA emergency room (ER) after hours only to have them not watched and walk away unaccounted for.

In October 2014, Phoenix VA social worker Penny Miller admitted to improperly accessing my own Health Insurance Portability and Accountability (HIPAA)-protected Veteran Medical Records. This was only the start of improper and unlawful behavior that would persist over the following year.

On December 6, 2014, I came forward to the Office of Special Counsel (OSC) regarding the unsafe treatment of suicidal veterans, along with my records being improperly accessed.

On January 12 and 13, 2015, ABC 15 ran stories regarding my OSC complaints. On the 13, hospital director Glen Grippen held a meeting with leadership of the Phoenix VA, to include Chief of Staff Dr. Darren Deering and VA Legal Counsel Shelley Cutts. Grippen proposed to terminate me for being on TV. Cutts advised Grippen that it was illegal to remove me because of the Whistleblower Protection Act. But then Cutts stated, "Brandon could possibly be removed for unrelated misconduct." The problem with her statement is I had an exceptional employment record.

On January 20, my section chief, Dr. Carlos Carrera, questioned my mental health. Later that day, I had a social worker accuse me of threatening him. It was simply not true.

On the 21st, Director Grippen met with me to share my OSC concerns. The director made an eerie comment. He stated, "Brandon, I just want you to know you are not being terminated yet." He actually used the word "yet." He admitted to saying this in his Equal Employment Opportunity Commission (EEOC) testimony.

On the 23rd, Social Work Chief David Jacobson held a meeting for 15 to 20 employees. An employee made an audio recording. An ER social worker stated "five suicidal vets had walked out of the hospital during the past week," and Jacobson responded, "We have been really lucky that nothing bad has happened yet. It was sheer luck." This proved suicidal vets were walking out of the hospital.

On February 2, I was placed on administrative leave for allegedly threatening other employees. The letter stated I could receive care as a vet, but I had to check in and out with the VA police. I immediately called the OSC to begin a retaliation investigation.

On the 3rd, Grippen shut down my highly successful 52-week Motivation for Change treatment program. Seventy-one high-risk

[1] The prepared statement of Mr. Coleman appears in the Appendix on page 72.

veterans no longer had long-term substance use disorder treatment. Those who are still alive still do not.

On the 4th, employee Jared Kinnaman came forward to the OSC stating suicidal veterans were being mishandled.

On the 26th, I attended a fact-finding regarding my placement on admin leave. I was personally escorted by VA police Lieutenant Robert Mueller. Lieutenant Mueller made me walk in front of him through the main hospital like I was a criminal. I was told by the fact finders after the meeting I would be cleared of any wrongdoing.

On March 6, employee Lisa Tadano came forward to the OSC claiming suicidal veterans were being watched by janitors and volunteers. She learned employee Penny Miller had also accessed her treatment records without reason.

On the 12th, I met with Secretary Robert McDonald when President Obama came to Phoenix. I told the Secretary it was highly questionable that I can have a one-on-one meeting with the most powerful man in the VA, yet if I go to the Phoenix VA for medical care, I have to check in and out with the VA police.

On the 16th, the Veterans Benefits Administrator (VBA) said my service-connected injuries had improved and proposed to reduce my disability benefits by over $300 per month. The timing was highly suspect.

On the 19th, I received a letter from Grippen stating I was no longer required to have a police escort. To date, I have never received a letter clearing me of wrongdoing.

On April 9, I had a second sensitive patient access report (SPAR) pulled and learned two additional coworkers had improperly entered my medical records.

On the 14th, I was walking through the VA hospital on my way to a 12-step meeting with friend and former Navy SEAL Carl Higbee. We were confronted by Grippen. I told Grippen what I was doing and went to attend the meeting that was open to the public.

Six days later, on April 20, I received a "gag order" from Grippen forbidding me from speaking to any other Phoenix VA employees but saying I could get medical care as a vet. How does a veteran get medical care without being allowed to speak to a VA employee?

By the 24th, over a dozen media outlets contacted the hospital forcing Grippen to amend the letter acknowledging my right to free speech.

On August 12, I pulled a third SPAR report and learned another administrative officer named Troy Briggs has accessed my records. I have not received care since January 2015 at the Phoenix VA when I got these eyeglasses, yet this employee was in my records on April 20, the same day Director Grippen placed a gag order on me. Mr. Briggs is even cc'd to the gag order letter. Why would he be in my record on this same date?

In closing, it is a privilege to work for the VA, not a right. All employees, including directors, must be held accountable. Today I am calling on the Committee to ask for a Department of Justice (DOJ) investigation into the improper accessing of my HIPAA-protected veteran treatment records as retaliatory acts and as a criminal act. I am also asking the Committee to call for an investigation into Grippen's retaliation against me, including placing me on

admin leave on baseless grounds, and for his attempting to manufacture grounds for my removal. His actions violated Federal whistleblower law.

I find it sad that the only time Congress can get an honest answer from the VA is when whistleblowers are asked to testify. There is something deeply disturbing about that fact.

Thank you for the allotted time today.

Chairman JOHNSON. Thank you, Mr. Coleman.

Our next witness is Joseph Colon. Mr. Colon is a Navy veteran and a credentialing support analyst at the VA Caribbean Healthcare System in San Juan, Puerto Rico. Mr. Colon raised concerns about unfair hiring practices, improper veteran care, and misconduct by upper management. Mr. Colon.

TESTIMONY OF JOSEPH COLON,[1] CREDENTIALING PROGRAM SUPPORT, VA CARIBBEAN HEALTHCARE SYSTEM, SAN JUAN, PUERTO RICO

Mr. COLON. Good morning, Members of Congress. My name is Joseph Colon. I am a credentialing program support at the VA Caribbean Healthcare System in San Juan, Puerto Rico. I filed for whistleblower protection in August 2014, and my case settled in July 2015. Despite the above, retaliation against me and others similarly situated continues at that facility.

Before I provide my account of the events that have taken place with me, I would like to thank Senator Ron Johnson, Ranking Member Thomas Carper, and the Committee for their leadership and for allowing me the opportunity to be a part of the hearing and to explain what happens to a whistleblower that comes forward.

The whistleblowers in Puerto Rico's facility really need the help from this Committee to ensure that whistleblower retaliation does not keep on happening at our facility and that the supervisors are held accountable. Unfortunately, our resident commissioner, Pedro Pierluisi, does not even issue one statement against whistleblower retaliation that occurs very often at this facility. Without proper oversight from our representative in Congress, it makes it even more difficult for us whistleblowers in Puerto Rico.

There were numerous issues that I reported: a physician who killed a veteran while doing an authorized procedure that his spouse needed for her residency program; Mr. DeWayne Hamlin's arrest for drunk driving and having a controlled substance without a prescription; director absences; veterans mental health issues; chief of staff salary concerns; a physician that gave an improper dosage to a Veteran ordered the veteran's medical record be documented with incorrect information; physicians practicing with expired medical licenses and without clinical privileges; Legionella found in the physical therapy pool; community living center director, who was the direct supervisor of the area that was not helping elderly veterans with bathing, using the bathroom, feeding, and drinking, was promoted to associate chief of staff of geriatrics and extended care; registered sexual offender that provides disciplinary recommendations to management; unfair hiring practices, and limiting opportunities for veterans from outside the facility to apply

[1] The prepared statement of Mr. Colon appears in the Appendix on page 78.

for jobs; my immediate supervisor's fraud with the travel voucher program; the retaliation that I experienced from top levels of management at the VA in San Juan; investigated four different times for the same allegations; I was illegally placed on a permanent work detail on two different occasions; issued a proposed removal on two different occasions; received a 3-day suspension; no performance appraisal issued to me for the 20 months when I was on detail; non-selections when I applied for other positions in the hospital.

The retaliation and harassment that I have experienced after the Office of Special Counsel settled my retaliation claim include: moved the Credentialing and Privileging Department from the fifth floor of executive suite to an office area with no windows on the third floor; the afternoon prior to me returning to my position, the Human Resources Manager Mr. Omar Ahmed issued an email warning his personnel that share the same lounge with me to not discuss any Human Resources business in the lounge area; no electronic email access for over 2 weeks; no work assignments for 3 weeks; expired my high blood pressure refill medication without notifying me; not selected for the clinical administrative specialist position, even though I was the most experienced member of the Department. The two panel members that interviewed me are the same members that I reported wrongdoing about.

Unfortunately, at the VA Caribbean Healthcare facility in San Juan, this is not the only incident of retaliation that has occurred under Mr. DeWayne Hamlin's and Miss Nayda Ramirez's and Dr. Antonio Sanchez's leadership. These three individuals are directly responsible for all cases mentioned in my statement.

Miss Rosayma Lopez, was issued a termination letter because she would not fabricate anything against me in her fact-finding.

Dr. Ivan Torres reported numerous concerns with the compensation and pension physicians who were not complying with the compressed time work schedule. Both cases are right now with the Office of Special Counsel.

Management here in San Juan, Puerto Rico, actually reward people that actually help them build a case to fire a whistleblower.

Miss Maritere Acevedo, who conducted the fact-finding against me, was rewarded as the quality management director, even though she stated in my fact-finding, "In terms of Mr. Colon going over the chain of command and gathering information, this is seen as a pattern that does have an impact on the efficiency and effectiveness of his unit." She also believes there is a potential ethical issue for becoming a witness in a discriminatory case.

Mr. Victor Sanchez was rewarded with a promotion as medical administrative supervisor in Mayaguez even though he sanitized and deleted a portion of the document that was used against me and he could not provide the original document when the investigator asked for it.

As you can see, in Puerto Rico, both these people were rewarded with better positions, but Miss Rosayma Lopez was issued a termination letter. The difference is because Miss Rosayma Lopez was ethical and failed to do what management wanted her to do. There is no better example that shows management's unethical behavior and what levels they will go to fire the whistleblower. The Sec-

retary of the Veterans Affairs must do the correct thing and place Mr. DeWayne Hamlin, Miss Nayda Ramirez, and Dr. Antonio Sanchez on detail until an accurate investigation is completed regarding their conduct and their behavior toward those who dare to bring into the light abuse and mismanagement.

If the Secretary of the Veterans Affairs fails to do so, he actually is accepting that a whole executive team can participate in retaliation and he actually supports it. How many veterans are being hurt because employees live in fear of retaliation? How can you run a successful organization without accountability?

It is easy to retaliate against someone when the supervisor does not have to pay for attorney fees, is not held accountable, and the American taxpayers foot the bill when compensatory damages are being paid.

I truly believe that since the Secretary of Veterans Affairs has failed to impose discipline to his employees, Congress should give that authority to the Office of Special Counsel to discipline employees who are found to have retaliated against a whistleblower. It is time to really protect future whistleblowers and implement a zero tolerance policy in regards to whistleblower retaliation.

Thank you again for this opportunity. I welcome your questions on the issues I have noted or any items I have submitted to the Committee.

Chairman JOHNSON. Thank you, Mr. Colon.

Our final witness on this panel is Shea Wilkes. Mr. Wilkes is an Army veteran and a licensed clinical social worker at the Overton Brooks VA Medical Center in Shreveport, Louisiana. Mr. Wilkes raised concerns about secret wait lists at his facility He is also the co-founder of the VA Truth Tellers, a group of VA employees nationwide who have suffered hardships since reporting wrongdoing within the VA. Mr. Wilkes.

TESTIMONY OF SHEA WILKES,[1] LICENSED CLINICAL SOCIAL WORKER, OVERTON BROOKS VA MEDICAL CENTER, SHREVEPORT, LOUISIANA

Mr. WILKES. Ladies, gentlemen, fellow Americans, I appreciate the opportunity to speak with you today in our great Nation's capital, a capital that symbolizes courage and a free way of life that so many have stood tall, strong, and given their life to protect.

Your continued concern for the state of medical care being provided to our Nation's veterans is greatly appreciated. I thank everyone in this room for their continued efforts to right the faltering Department of Veterans Affairs.

Throughout history, the success and failures of countries across the world have often balanced upon how that country has cared for those who have borne the battle. I believe all of us here today can agree a country that does not care for its veterans can quickly become a rudderless ship destined for disaster, for a country that will not live up to its promises made to its veterans willing to give everything to protect a way of life will quickly forget promises to its people.

[1] The prepared statement of Mr. Wilkes appears in the Appendix on page 82

In our great Nation, there is an overwhelming support for our military and our veterans. From Bunker Hill to Helmand Province, Afghanistan, our Nation's veterans have faced what seemed to be insurmountable odds only to succeed time and time again in protecting a way of life preserved in a sacred document that resides a short distance from where we sit this very day.

For some time, we the people have entrusted the caring of our Nation's veterans to the Department of Veterans Affairs. Unfortunately, reality here today is somehow this trust is being strained by what has become a bloated, unaccountable bureaucracy whose leadership is incompetent, often more concerned with its public image, and perpetrating its own existence than it is with providing first-rate medical care to our Nation's veterans, which they have earned and deserve.

I am here today to fight for accountability, leadership, and competency in our VA health care system. I am here for those Truth Tellers who have shown integrity, despite knowing for certain that despicable and hateful retaliation will be imposed for coming forward. I am here for my brothers and sisters at arms, both past and present, and future, to assure our Nation does not forget where it comes from, who is protecting it today, and who is going to assure it is protected forever: veterans.

What has happened to Shea Wilkes will not even be a footnote in history. However, I hope my voice will be heard by our leaders and the American people. I hope that you will hear VA Truth Tellers' voices within my voice and will unveil the truth hidden inside the walls and swept under the rugs of the VA system.

I hope that our Truth Teller voices and your action will become a resounding chorus demanding and forcing change for our heroes.

I was asked to tell you my story, but, no, I am not here for myself. If I were, my story would be of little interest. I can tell you that my story is not compelling because it has happened to Shea Wilkes; rather, it is compelling because it is a mirror image of how VA whistleblowers across this country have been treated.

My situation, like other whistleblowers across this Nation, is a product of a contagious disease within the very fabric of the VA system itself. Whistleblowers are shunned, isolated, defamed, and accused of trying to destroy the VA. Those of us Truth Tellers that are also veterans have our VA personal medical records accessed and information in those records used in attempts to discredit us. We are placed in positions away from others, oftentimes below our ability levels. We are never given the same opportunities we once had.

Truth Tellers are labeled problem children, troublemakers, crazy, and much more. We are put under criminal investigations for nonsense in an effort to scare and intimidate. Once a Truth Teller comes forward, they are alone, left gasping for air, and desperately trying to protect themselves from the good old boys of VA that have them in their cross hairs.

I could continue, but we know the VA is still hiding issues and not being truthful. We know VA OIG has not been independent but yet working with the VA to damage control, whitewash, and intimidate Truth Tellers and potential whistleblowers. The VA OIG investigations have not been after the truth as they would attempt

to make us believe. VA OIG investigations have been half-assed and shoddy. We could line whistleblowers up from around this country out this door and around this building and ask about the VA OIG. The overwhelming majority would answer: "The VA OIG is a joke."

No longer are Truth Tellers allowing the VA OIG to dictate, intimidate, bully, and isolate, and they cannot stand it. VA Truth Tellers have the inside knowledge of how deeply embedded corruption is in the VA system, and we are going to continue to share it. VA Truth Tellers across the Nation are joining to have one voice, and it has made the knees of the VA giant shake.

In closing, I say to those in this room, I say today the VA deception, deceit, and lies have gone on long enough. I speak to the leaders of Congress, OSC, new OIG leadership, VA Truth Tellers, potential whistleblowers, American taxpayers, and veterans, we must draw a line in the sand today and say, "No more." No more will we allow VA leaders to take aim at whistleblowers brave enough to expose VA wrongdoings. No more will we allow the VA wasteful and fraudulent spending of American tax dollars. No more will we allow the VA to provide those that have borne the battle anything but the best care in this world. And no more will we allow the VA to chip away at the very foundation this country has stood on for generations, that our veterans have drawn a weapon to protect.

The time has come for each of us in this room to stand together—E Pluribus Unum—and to tell the VA, "No more."

Thank you for your time. May God bless each of you and may God bless the United States of America.

Chairman JOHNSON. Thank you, Mr. Wilkes, and thank you all for your powerful testimony.

I will start with you, Mr. Wilkes. In reading your testimony, the written testimony, I was struck by the criminal investigation, the intimidation. Can you just talk to me a little bit about exactly what you did? My understanding is you took—you understood the wait list, that veterans were waiting and obviously not getting the care they deserved. But you presented that to the Office of Inspector General, which would have been the proper venue. And then later on you were really the target of a criminal investigation. Is that true?

Mr. WILKES. Yes, sir. Let me state this: Wait lists are just one tool that was being used for manipulation of scheduling and numbers, and, I brought forward—I knew there were wait lists. I was actually, in mental health leadership, had done stuff for the directors, and I had heard about it in meetings, and I just kind of followed up with it and just kept seeing it. And probably about 10 months before hand, in June 2013, 10 months before Phoenix came out, I reported it to the Inspector General (IG) and I never heard from it. Basically I was systematically removed from any leadership over time.

Finally, when Phoenix came out, I said, "You know what? This is my shot. This is another shot that I may get." And I did report that. After encouragement——

Chairman JOHNSON. But, again, reported it to the Office of Inspector General.

Mr. WILKES. Yes, sir, again, and I reported it and went to the media. And when they came in finally about a month and a half after all this, they called, they said they wanted to meet with me. I said yes. They asked, "Hey, you want to come off campus and meet?" And I said, "I am not bringing this list off campus." I said no. And I said, "I have it here secured and everything. It is on my hard drive." And then what happened after that is they came up, we talked, they secured the list, and then it went—they said, "We are going to go talk to people," which they ended up talking to basically those that, if there was a list, would have something to lose.

Then we found out later about some of the questions. They came back. I was, like, oh, this does not make any sense. So at that time, I contacted my lawyer, and we were told, yes, there was an issue with how I got the list and of that such. And basically after that, they never really asked anything about that.

Chairman JOHNSON. So, again, you were expecting the Office of Inspector General to come in and be shocked at this wait list. But instead what you found is the Office of Inspector General was basically coming in and kind of laying the groundwork for a potential criminal investigation against you for revealing the wait list.

Mr. WILKES. Right. My opinion——

Chairman JOHNSON. So it is basically retaliation by the Office of Inspector General against you.

Mr. WILKES. Right. My opinion is they came in to basically damage control and scare the heck out of me and anybody else that knew about it and potentially—there are witnesses that know that it was there. There are witnesses that know they were going in and out of scheduling and doing that. But when they did that, everybody shut down. Stories changed.

Chairman JOHNSON. So, obviously, one form of retaliation is intimidation.

Mr. WILKES. Yes, sir.

Chairman JOHNSON. To prevent you from and, by the way, prevent anybody else from coming forward, when you say damage control.

Mr. WILKES. Yes.

Chairman JOHNSON. Mr. Kirkpatrick, again, thank you for your powerful testimony. Were you aware, as you have gone through the records now and you have seen some of these things, were you aware—was your brother, Chris, ever given any warning before he was called in to that one meeting and fired?

Mr. KIRKPATRICK. Not to my knowledge, no. I think he kind of felt that that was a potential outcome, but I think he was surprised when he saw it that day. And I believe he contacted Lin Ellinghuysen right away saying he was concerned about this, and then she mentioned that, well, we should prepare for the worst, that it might be, your termination.

Chairman JOHNSON. And the termination was predicated, the rationale was he missed a few days or abused some free time. I mean, that is basically what the termination was about?

Mr. KIRKPATRICK. Essentially, yes. One of the allegations was that he brought his dog into work one day, which they did not deny that he had permission to do so; but that when he stepped away, the dog, made a mess and somebody else had to clean it up. Other

things they pointed out were that he was taking a lot of vacation time. I wanted to include that in my statement but for time reasons I did not, but his response was that for his own well-being he had to take additional days off because he did not have the support or anybody to talk to, and he was being overloaded. He was a graduate psychologist, and from what I can tell, I mean, he had a full caseload, very complex cases, and——

Chairman JOHNSON. I am going to give you an opportunity right now to kind of lay out your recommendations based on that, but I just want to quickly drill down because I think it is tragic, quite honestly. It is to me just unbelievable. I come from the private sector. You always hear "at-will employment." It is really not so. I mean, certainly as a private sector company, you have to go through a series of steps—warnings, counseling, talking to people—before you would even consider terminating someone just out of basic humanity, but also from a legal standpoint. And yet your brother was basically called into an office, terminated for what I would consider the flimsiest of reasons—and, again, from my standpoint, as a result it is obvious he was being retaliated against because he was raising the issue of drug overprescription resulting in real harm to our veterans.

But in your testimony, you have a list of recommendations. Again, I think it is powerful testimony.

Mr. KIRKPATRICK. I do. Thank you.

Chairman JOHNSON. I want everybody to read it, about the pressures that those individuals like your brother who are trying to help our veterans deal with some very difficult psychological and mental issues and addiction issues, the pressures they are under and how there is just not much help for them.

Mr. KIRKPATRICK. Thank you. I appreciate the time.

Chairman JOHNSON. Please, talk a little bit about that and lay out those recommendations.

Mr. KIRKPATRICK. Well, we have quite a few here. I will just read through them. And let it be known, too, that I consulted with Lin Ellinghuysen again and to kind of see what she thought would also be the most effective recommendations.

No. 1, we encourage—I am sorry. We urge Congress to mandate the development of a comprehensive support system for VA medical and mental health care professionals that provide needed consultation services with trained professionals as part of their employment and not to be seen as private treatment. These support services and consultations must maintain strict confidentiality. Currently, all that is offered at the Tomah VA are one or two sessions with a VA-provided counselor; after that, employees are left to manage these very intense job duties on their own without time to debrief, refresh, or regroup. Particularly, psychotherapy with veterans is difficult and draining and can take a great deal out of a clinician emotionally and physically.

No. 2, if not licensed when hired, graduate psychologists are required to be licensed within 2 years. They are not given adequate time to prepare for the exam. Mentors could ensure that there is appropriate patient care assignments and time set aside for study. Note: Prep for exam requires 20 hours a week of study time for 3

to 6 months. And that recommendation actually came from somebody who has completed it.

As a graduate psychologist, Chris was expected to counsel veterans with complex needs, facilitate group therapy, participate in care planning team meetings, along with all of the required reporting and documentation.

No. 3, develop Veterans Health Administration (VHA) protocols for investigation of suicides of employees and recently terminated employees. The Tomah VA management and police did not investigate my brother Chris' death.

No. 4, develop VHA protocols for addressing threats patients make against staff.

No. 5, we also request that lawmakers investigate the pervasive use of extended temporary appointments within the VA health care workforce and the abusive use of terminations and other personnel actions against temporary and probationary employees and mandate additional protections, both statutory and administrative, for these most vulnerable employees who pay the heaviest price when they question the way of doing things.

No. 6, we urge Congress to take steps to ensure greater accountability for VA front-line managers, mid-level managers, and upper management who engage in retaliation against whistleblowers and other front-line employees who speak up for veterans' needs.

Seven, additionally, we urge Congress to review the current reporting structure for the chief of police at VA medical centers. Currently, they report to the medical center director rather than a separate entity that can address mismanagement or staff concerns without interference, such as the alleged illegal drug activity at Tomah.

Eight, we are thankful the Senators and Congressmen are addressing and putting into place checks and balances that will ensure the safe ordering of opioids as well as the development of guidelines for the safe combining of opioids with other addictive drugs in an earnest effort to keep veterans safe.

And I would like to point out, in addition to that, that Jason Simcakoski, who died last year from mixed drug toxicity, he died from essentially the same thing that my brother was addressing, and it is just beyond tragic.

Last, but immensely important to our family, is our request—and this is a personal one—that Chris' Official Personnel File and all information be sent to myself, Sean Kirkpatrick. It is also requested that any and all Tomah VA supervisory notes, reports of contacts, et cetera, related to Christopher Kirkpatrick be sent to myself, Sean Kirkpatrick.

Chairman JOHNSON. Thank you, Mr. Kirkpatrick.

Mr. KIRKPATRICK. Thank you.

Chairman JOHNSON. Senator Baldwin.

OPENING STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I want to thank you and the Ranking Member, Senator Carper, for holding this hearing, and I especially want to thank the witnesses for their powerful testimony that will, I think, guide us in our future actions.

As we have certainly seen in Tomah, Wisconsin, and, indeed, the rest of the Nation, the role of whistleblowers is critical—in fact, heroic—in running an effective organization. And agencies need to be much more open to accepting constructive criticism in order to improve an agency such as the VA, which has the tremendously important mission of taking care of our Nation's veterans.

Mr. Kirkpatrick, I want to thank you so much for your attendance here today and also for mentioning Ryan Honl in your testimony.

I also want to appreciate the fact that in your written testimony you shared the specific recommendations that you just outlined for the Committee that are really key. One that I would like to have you speak to a little bit more is the issue you raise about temporary or probationary workers.

As we saw in Tomah with many whistleblowers it should not matter if an employee has been employed for 10 days, 10 months, or 10 years in terms of our treatment of them if they step forward to help veterans. I know this is a factor you have become aware of. We are working on legislation to address this issue. I very much appreciate your family's input but if you could speak more to the position that temporary or probationary workers are in when they come forward as whistleblowers.

Mr. KIRKPATRICK. Thank you, Senator Baldwin. I find it curious that, probationary and temporary employees—and I am really just drawing from my brother's experience, but the amount of responsibility that they are given and especially considering that they are lacking the support that I mentioned as well, that they can just be tossed aside really without any sort of third-party review, any sort of accountability. I mean, it is outrageous.

In Chris' case, as Chairman Johnson pointed out, I think any independent person who would have looked at the reasons why they were terminating him would have come to the same conclusion, that these were ridiculous reasons and that it was clearly a case of retaliation. He was not afforded that protection because of his probationary status, and something, I think, needs to change with that.

I think if we are going to—I mean, really, as, it was pointed out before, serving veterans is a privilege, and if we are going to put people in that position, a privileged position like that, we should provide them with the protections that they deserve, especially considering, a lot of these people, my brother included, he was not in the military, yet he was hearing firsthand accounts, from people with PTSD and hearing very hard things to hear for somebody, especially as a graduate.

I think when you also add into the fact that to take that extra step and to point out what you see is wrongdoing and bring that to the attention of people, knowing that you do not have those protections, it takes a little more guts, I think. But that should absolutely be changed, and I do not see why anybody would disagree with that.

Senator BALDWIN. Thank you.

Mr. KIRKPATRICK. Thank you.

Senator BALDWIN. I want to note the repeated testimony we have heard today and on previous occasions about inappropriate access

to whistleblowing employees medical records. We have heard such stories also at the Tomah facility regarding other whistleblowers who have stepped forward.

I would like to ask Mr. Coleman and Mr. Wilkes whether there is an information technology fix in VA's recordkeeping systems that would make it more difficult for an employee to access a fellow employee's medical records. What action needs to be taken with regard to this pervasive problem?

Mr. COLEMAN. I think, Senator, one of the things that can be done is to have maybe a two-party or two-employee system where, if there is a sensitive record like mine, because I am a Marine Corps veteran, that if an employee goes to get in the record, that another employee or a supervisor has to approve it for that to happen. The reason that would be important is this has happened four times to me, and when it has happened, I mean, I have heard excuses such as it was an innocent mistake—this is from the VA—or they were trying to get into a veteran's record with a similar name, and "I do not recall being in the record." Those were excuses that were actually given. And I do not know if any of the Senators have ever had a young puppy dog, but that first day when you leave a puppy dog in your apartment or your house and you go off to work and you come home and it has chewed up your shoes or it is wet on your floor, and you look at that puppy dog, and that puppy dog cowers like it has done something wrong, that is the same look that I got from Phoenix VA administrators after they gave me those excuses. They sat there quiet, all balled up, hoping that I would just stop talking about it and it would go away. It reminded me so much of a puppy I had one time, and that is what has to stop, ma'am.

Mr. WILKES. I have been fortunate to talk to 50-plus whistleblowers across the country, and 100 percent of those that are veterans have had their records accessed—100 percent, every single one of them. And, what can we do? There is no accountability. I was under investigation for a year, for having a list that was not supposed to exist, for possible privacy violations, but yet these people went into our records, and they face nothing. They do nothing.

The whole thing with accountability, somewhere along the line there has to be accountability. And if you do it, there has to be—you have to say, "Hey," and show those others that they are going to do something to them. There are ways that they have in place to say, hey, there is a big thing that pops up, this person is also an employee, so-and-so accessed—it tells them before they even go in there. I mean, 100 percent of whistleblowers/veterans that I have talked to have had their records accessed by people.

Chairman JOHNSON. Thank you, Senator Baldwin. Senator Tester.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Yes, thank you, Mr. Chairman, and I want to thank Ranking Member Carper also for holding this hearing, and I want to thank you all for your testimony. I very much appreciate it.

I just want to follow-up on Senator Baldwin's question with either you, Mr. Wilkes, or you, Mr. Coleman, and that is, why—and

maybe I am just not seeing it. Why are they accessing your records? What are they doing?

Mr. COLEMAN. What they do, Senator, is they access our records. Some of us have had mental health treatment after coming home from our time in the service. Really, it is none of their business to be in there. However, as Shea can tell you further about, what they do is they go into our records, and such as in my case, on January 20, when everything was kind of hitting the fan, I was called into a meeting with my section chief, who happens to be a psychiatrist, Dr. Carlos Carrera, and he asked me, he goes, "I just want to find out about your mental health," and he started questioning me about my mental health. And I said it was highly suspect that he waited until after I was a whistleblower to ask me about my mental health. However, he never came to me after each of the six veterans committed suicide, he never once asked me about my mental health. So the timing is always highly suspect with these people.

Senator TESTER. But it is accessed to see if you have had mental health treatment? That is what they are doing.

Mr. COLEMAN. I do not know, sir. I do not know exactly what they are getting at with that. I just know that they are violating HIPAA in doing it. But I know that they do use it against us, such as they have done with me.

Senator TESTER. By the way, I think your recommendation is well founded. I think it is a good recommendation.

Mr. COLEMAN. I think it is a simple one.

Senator TESTER. Yes. Mr. Wilkes, would you——

Mr. WILKES. In my case, yes, I mean, I was brought in by my boss and sat down with him one on one, and he flat out asked me, "Have you seen this mental health provider?" And I had. I mean, I am an Afghanistan veteran, and, I had come back and I was seeing those, and I had quit sometime before, before I even came back to work at the VA from the vet center. And he basically told me, he said, "Well, some of your colleagues are questioning your stability."

Senator TESTER. And this was after you were a whistleblower they did that?

Mr. WILKES. This was after I had turned it in June 2013, yes. "They question your stability and are saying you are unfit to lead."

Senator TESTER. I got you. How long did you work for the VA before all this came down? I just want to try to get a timeline here.

Mr. WILKES. 2007.

Senator TESTER. 2007 you started, and you put forth some problems at what point in time?

Mr. WILKES. I had brought forth problems starting in 2012.

Senator TESTER. Got you. And they never talked about your mental health until after you brought forth problems.

Mr. WILKES. Until I reported it to the IG.

Senator TESTER. Cool. Not cool, but thank you.

Mr. Kirkpatrick, I just want to say thank you for your recommendations. Oftentimes we get a lot of panelists in here, and to be proactive and talk about what you see as potential solutions is very helpful. So I want to just thank you for that.

And this is for any one of you, Coleman, Colon, or Wilkes. What is the formal feedback mechanism for VA employees who want to

bring forth a grievance to the attention of management? Is there a formal feedback mechanism? Go ahead, Shea, if you want.

Mr. WILKES. There is in place—I mean, they always want you to keep it and follow your chain of command, and they always suggest that you do that.

Senator TESTER. Yes.

Mr. WILKES. But, unfortunately, that is not working. And, unfortunately, when you report to the IG, if you take that step, the IG only takes a certain number of cases, and a lot of times they will send the report back to the Veterans Integrated Service Network (VISN), which goes back to the director, and then you are in trouble.

Senator TESTER. Right. So there is a mechanism. Are you told about the mechanism for grievances and are you told about whistleblower rights in any sort of training that the VA offers up?

Mr. WILKES. We do have a lot of Talent Management System (TMS) trainings, which is our online training system that we go through, and you do have classes on those. You do every year.

Senator TESTER. And it does cover whistleblower, it does cover how you report a grievance and all that? I am just curious.

Mr. WILKES. It does cover whistleblower. I am not sure about the union grievance process.

Senator TESTER. OK.

Mr. COLEMAN. Can I add to that, Senator?

Senator TESTER. Absolutely.

Mr. COLEMAN. The problem between our front-line supervisors and ourselves is that when all this happened with me, I told my front-line supervisor, because, once again, we are veterans, I believe in my chain of command.

Senator TESTER. Right.

Mr. COLEMAN. It is just grilled into you. And when I came forward to my front-line supervisor, the first thing out of her mouth when I said I was coming forward regarding suicidal vets, she goes, "That is how people get fired."

Senator TESTER. Oh, my God.

Mr. COLEMAN. Instead of suicidal veterans walking out of our hospital that everyone knew and we needed to fix it.

The next time, I was walking through the hospital on my way to a meeting with the director when one of the assistant social work chiefs said, "Do not rock the boat," as I walked by him. This is the kind of comments and wrongdoing that we are getting in our own hospitals by our front-line people that we are told to come through. That is where the disconnect is at, and that is the cancer that we have to fix within each of these facilities.

Senator TESTER. I agree. It makes me wonder what kind of training—other than professional training, what kind of training the VA does for your front-line supervisors.

Look, mental health is a huge issue. You guys know that. I think every one of you are in that field, right? And you have come out of the military. You understand the impacts that are going on with the wars in the Middle East, how it is a signature injury coming out. But denial is not a solution, and so my time is up, but I just want to express my appreciation for you folks coming forward and

bringing forth problems and solutions to those problems. I very much appreciate that. Thank you.

Chairman JOHNSON. Thank you, Senator Tester. Senator Ernst.

OPENING STATEMENT OF SENATOR ERNST

Senator ERNST. Thank you, Mr. Chairman. Thank you, gentlemen, so much for being here today.

I will state again—I have said this many times in the short 8 to 9 months that I have been here—that this is one of my priorities, is working with veterans and mental health issues. The first bill I proposed was working with veterans that have mental health issues and allowing them greater access. And so I do want to thank you. My condolences on the loss of your brother, Sean. It is very sad.

Mr. KIRKPATRICK. Thank you.

Senator ERNST. This is an issue I am extremely passionate about, and I think today's hearing just is reemphasizing to me that we have a corrupt and broken VA system. And when I hear that supervisors, other workers are more concerned about their own jobs than they are about the veterans, we have an issue. We have an issue, folks, that needs to be fixed. And I do not know how many hearings we are going to have until we get to actually addressing the situation. I hear a lot of talk, but we need to figure this out. So, again, I am very passionate about this issue, and thank you for coming forward, for being brave and doing the right thing.

When it comes to accessing your health records, I just want to state, just for everybody, it does not matter what the reason is. They should not be accessing your health records. That would be like saying it is OK for us to access anyone here in the audience, their health records. It is wrong. It should never, ever occur. Never without your authorization. So I just want to emphasize that. It does not matter why.

Mr. Coleman, do you believe there are many alternatives for veterans who feel they are not receiving timely or adequate mental health care at their local VA?

Mr. COLEMAN. Thank you for asking me the question, Senator. I do not know if you read the article by Dave Phillips, the front page of the New York Times on Sunday. It was about the plight of Second Battalion, Seventh Marines, who have lost, I believe it is, 13 members to suicide after their deployments in Iraq and Afghanistan. The picture I have in front of me is me and my two Marine Corps sons. Not only am I a former Marine, but I make Marines. The one on the right is with 2–7 currently.

In that article, they talk about how many of these veterans came to the VA for health care and were turned away. In one instance, they had a 22-year-old female social worker or whatever that told him that the loss of his buddies was like breaking up with a girlfriend and he just had to get over it. Well, we do not just get over it. And that is not right. And that is why I think that these guys and girls, when they come home from theaters of war, should have the right to go wherever they feel comfortable. We owe it to them to send them anywhere they feel comfortable. If it is a counselor in another town that they want to go to and they are going to open up and talk, then we should allow them to do that, because

once they have committed suicide, it is too late. There are no second chances.

Senator ERNST. That is right, and you do believe that opening up for greater access, whether it is at the VA or whether it is through a community clinic, peer-to-peer supports, those are ways to address it.

Mr. COLEMAN. Any of those, ma'am. And the reason I do not agree with the number of 22 per day—I think that is a number of suicides—I believe that is a number fed to us in the hopes that we will all shut up and make it go away. That study was sponsored by the VA. It did not include the States of California, Texas, and Illinois. And I do not know about you folks, but when I was in the Marine Corps, over half of us were from California and Texas. Some of the guys written about in that article that have committed suicide are from California. They also do not count the phenomenon of suicide by cop. I have had two veterans that were killed by police officers. I am not saying it is the police officers' fault, but they pretend to have a weapon or they pull a weapon. The VA does nothing to report those as suicides. The number of 22 per day is inaccurate, and we need an independent third party to come in and do a complete study to show us what the real number is so we know. Once we get a real number, then we will know what a big deal it is, and then we can fight it together.

Senator ERNST. And I use that 22-a-day number all the time, and I think that is appalling enough. But I think you are probably correct, Mr. Coleman, in your assessment.

And for all of you, in your experience, do you believe the VA management takes seriously ideas for reform, the implementation of the IG recommendations, or recommendations from staff members when they are seeking to improve these services at the VA? Do you think they take them seriously?

Mr. WILKES. VA leaders, it is a system of cronyism that has gone on for so long, and they protect each other. Rules and regulations oftentimes, they do not care. They use them when it benefits them. And I will tell you, one of the reasons why is because nothing ever happens to them. Even if you catch them—I have put policies in front of folks and said, "You cannot do this. This is the policy." They still do it. But nothing ever happens to them.

And, the IG makes recommendations, but they do not have to hold—I mean——

Senator ERNST. Who is holding their feet to the fire?

Mr. WILKES. Right.

Senator ERNST. Right. We should be doing that. Thank you, Mr. Wilkes. Mr. Colon.

Mr. COLON. I have always stated that it is great to have all these hearings, all new policies, all new recommendations and solutions. But since this scandal has broken, since Phoenix, we have not held one person accountable for any wrongdoing at the VA as far as whistleblower retaliation. The VA, what they do is the IG—I reported a couple things to the IG. The IG sent it back to the agency to investigate itself. And then they give it to the supervisor. The supervisor already knows who the whistleblower is.

So what I always truly believe is that you cannot police yourself. It is not the solution that you should do it. Like I said, the key

component that everything is failing to make the VA better and to do service for our veterans is start holding people accountable.

Senator ERNST. Very good. Well, I know my time is up. Do you have any other comments? Please.

Mr. KIRKPATRICK. If I may, with regards to that, I know that the people who seem to have been responsible for retaliating against my brother, as far as I am aware, are still employed at the VA. I do not know if that is a pending investigation, but that is unacceptable.

Senator ERNST. It is unacceptable.

Mr. KIRKPATRICK. And that is Dr. David Houlihan. And the human resources representative David DeChant.

Senator ERNST. Thank you. Again, my condolences.

Mr. Coleman, do you have any closing thoughts, very quickly?

Mr. COLEMAN. Ma'am, really quickly, I was just going to say the retaliation investigations, I was removed on hearsay. I was on paid administrative leave for 206 days until I was ordered back into the same retaliatory environment on August 17, which I refused to go until it is safe. So they are able to remove me on hearsay; whereas, we have a sworn affidavit from the H.R. chief showing that the director held this meeting to propose to fire me on January 13, and he is still showing up to work every day. I love my job helping vets get clean and sober. I would do it for free. And they removed me from that or took me out of that position to investigate hearsay, which was proven untrue in late February.

Senator ERNST. Thank you again, gentlemen.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, Senator.

Let me assure everybody, Senator Ernst, all the witnesses, everybody in the audience, there is a process to solving a problem, and this is the first step. We have to properly define it. We have to lay these things out. We have to highlight these problems. And, of course, the purpose of these hearings we have been holding—and they have been multiple; we also have our own investigation under way with Committee staff—is to highlight the problem, to get agreement. And let us face it, what you are seeing is bipartisan agreement. These are problems that have to get fixed. So now that we understand and we have highlighted it, we will solve it. We will be introducing legislation certainly under the jurisdiction of this Committee. It will get reported out, and we will put pressure on the system to get the things passed. So this is not just talk. This will result in action, and your testimony is powerful and will result in that kind of action. And the fact that we have representatives of the VA here, as they were in Tomah when we held the hearing in Tomah, and we listened to the powerful testimony of the survivors of the abuse there, this is what will result in concrete action to start solving these problems. So, again, thank you all. Senator Ayotte.

OPENING STATEMENT OF SENATOR AYOTTE

Senator AYOTTE. Thank you, Chairman.

Mr. Kirkpatrick, let me just add my condolences for the loss of your brother. And let me just say to all of you, in listening to the exchange you had with Senator Ernst, it is appalling, frankly, that

they can retaliate against you for really doing the right thing for our country and coming forward with a focus on making sure that our veterans are served based on things like hearsay when you have at heart what we want to have in our VA, the best to serve those who have served us, and that the people who have done this to you are still merrily on their jobs. And so I think the accountability piece is the key to all of this, people who are not focusing on caring for our veterans and those—we need to reward people like you who want to serve our veterans. And those people who retaliated against you should be fired, and I think the problem we have seen with all that we have heard of the deaths of our veterans and our veterans who have suffered, there have been very few, if anyone, held accountable for it.

And so within the organization it seems like the message being sent is, hey, keep covering everything up because, do not worry, you will keep your job; if you come forward, you are going to lose your job—which is the absolute wrong message.

And so, Mr. Chairman, I hope that we make sure that the legislative tools are there and that we hold people accountable. So I just want to thank you all for being here and for your courage in what you have done.

I also wanted to follow-up, just the one thing that many of us have focused on here is where is the priority. We have not even had a permanent Inspector General for the VA since December 2013. It has been 631 days. So if we look at where priorities are, it seems to me that that is being put low on the totem pole when we will not even put a permanent individual in that position. And many of us on this Committee—and I am going to do it again today—have called on the President, because he needs to appoint that individual and say this is a priority for our country.

And I would like to ask all of you, what would you like to see—rather than the Inspector General, obviously we need to get someone there with the importance of it, of a permanent position and back that person up. But once those recommendations are made and the investigation is done, what more teeth can we give that process so it is not just turfed back to the same group of people in the VA where there may be a good investigation done, but nothing is followed up on it. So I wanted to get your thoughts on what could we do, ideas you have for us, to make sure there is more teeth in that process. I will turn it over to whoever wants to go first.

Mr. COLEMAN. That is what we are here for today, is to get some teeth in the process, because like you have all stated, we continue to talk, and we all know there is a problem. However, they give their answers, and then we give them 3 more months, and then some new whistleblowers come back, and we do it all over again. The time for action is now.

Senator AYOTTE. Right.

Mr. COLEMAN. We are here to help. I think being part of the process, the nice thing about it is you have some front-line VA employees here. I was a grunt in the United States Marine Corps. I know both——

Senator AYOTTE. Semper fi.

Mr. COLEMAN. And I know that with some of these committees and stuff, such as Secretary Robert McDonald when he did the MyVA, a lot of these people that he selected—do not get me wrong. It is great, all these generals and stuff were there. But I have never seen a general have to use the VA for health care. I have never seen a general drive 150 miles and have an appointment canceled when he had to take a day off of work to feed his family. And no disrespect to the general and his service at all, but there needs to be more front-line people. There needs to be more grunts. There needs to be more, enlisted people involved in the process.

Senator AYOTTE. This has to be grassroots. They need to understand what is happening on the ground.

Mr. COLEMAN. They do, ma'am. And what the problem is is they are not listening to us. We are talking, and we are all about respecting the chain of command. However, when there is a breakdown in the chain of command, that is where you all come in, and that is where we need your help. And I agree with you. We need a permanent IG. It needs to happen. But from the grassroots part of it, we allow them to have their own investigations. The VA gets to investigate itself, and there is—I am sorry to laugh, but it is just—it is a sad joke. We have an audio tape of them admitting five suicidal vets walked out of my hospital right after I came forward. Someone should have said, "You know what? We messed up." They did not. They destroyed me when I told the truth. It played on CNN with Jake Tapper. It is just amazing.

So how much more evidence do we need on these people before we are able to take action? And that is why I hope you all are upset and I hope you are able to take action, because it is enough. It is enough today.

Senator AYOTTE. I am upset, and I know that many on this Committee are upset.

Mr. COLON. One of my recommendations in the statement that I provided, I think once the OSC concludes that a person retaliated, that they are given the authority to fire that person, because it seemed that the VA does not want to fire anybody.

Another thing that Mr. Brandon Coleman had touched on, I requested through the Freedom of Information Act (FOIA) to see how many directors, deputy directors, and associate directors are actually veterans working in the VA. Seventy-six out of 479 are veterans that are in executive positions for the VA, and that is a problem.

I stopped getting care at the VA for one reason 3 years ago. Once I came forward, I knew the type of behavior I was dealing with. So the care that I earned, I stopped going there, because I know if they access my record or they did anything, that they would not be held accountable. But I think the IG should make recommendations. Maybe they should have the authority if they found somebody that has found misconduct, that they should be the ones that should issue disciplinary actions.

One thing I have noticed through all this ordeal is the VA has failed to hold people accountable. And if that identity does not want to hold people accountable, then maybe we need to move forward with the IG and the OSC to start holding people accountable.

Thank you.

Mr. WILKES. I will say this: The bottom line is the VA is going to have to start telling the truth, and somehow we have to make them do that. Their PR machine puts out more propaganda than the Republic of North Korea. I am serious about that. And the problem with that is they are not accepting any responsibility. It is still going on. The facility I work at told me there are no—after I came forward, no access to care problems. But in March of this year, I had a consult put in for my yearly eye appointment. They scheduled me an appointment in June. I did not even know about it. They did not offer me any kind of outside fee-based. I put in another one in May. They had canceled the one in June because the doctor had quit, moved it to August. Still nothing. I called down to the clinic, and I said, "Are you all not going to offer me fee-based service or something?" They said, "Well, we do not do that. We do not do the Choice program." I said, "Look, you do not know who I am, but I am very familiar with this stuff." I said, "That cannot be right."

Now, I will give credit. When I called the chief of staff and the director, they got my appointment, and they said they were going to correct that. But it is still going on. It is still going on, and they are still putting out these numbers, and they say, "Well, we have 97 percent new leadership." Yes, you moved this director from this hospital to this hospital, and this one here to here. That is the kind of numbers they put out. They are very misleading.

Senator AYOTTE. Unfortunately, I am hearing those stories from my constituents also.

Mr. KIRKPATRICK. Well, being the only civilian here, I do not really have a lot of personal insight but since I have learned a lot about this since my brother died, it seems very apparent that there is a lack of transparency, accountability, and in a way, it is like the ugly side of war, almost the ugliest side, is, the people who return from it broken. They have put their life on the line. They have paid the highest cost. And, they should be given everything from this country, to hear 22 people, and that is probably way underestimated, it is outrageous.

It seems like the VA behaves as if it is above the law, and that is unacceptable. Personally, I have to say, this Committee is really the only entity out there that has taken my brother's case seriously, and I just want to let you guys know, on behalf of my family, we are eternally grateful for that. But, I hope at the same time that there is some power that you guys hold where, some change can be made here, a culture change or something. I mean, people's lives are on the line, and it gets swept under the rug. You do not hear about it, yet every day people are dying, people are suffering.

So I do not really have anything specific to say, but I think it is worth pointing out.

Senator AYOTTE. What you said today has been heard, and it has been loudly heard, so we appreciate your being here.

Mr. KIRKPATRICK. Thank you.

Chairman JOHNSON. Thank you, Senator Ayotte.

The power we hold is the power of your testimony, and I just want to underscore the point of this is just a basic first step because we have to have a transparent and independent Office of Inspector General. That is just a basic first step. And, again, we do

not have a permanent Inspector General. I wrote a letter to the President on January 22, 2015 asking for an appointment of a permanent one. Other Committee Members have asked for the same thing. We will ask again. We need a permanent Inspector General so we have a transparent and independent Office of Inspector General. That is just a basic first step.

So, again, let me call on the President of the United States to, as quickly as possible, appoint an independent permanent Inspector General for the Veterans Administration. We need one, and we need one now. Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. I want to thank each of you for being here today. I want to thank a number of you for wearing the uniform, and thank you for that service, and thank you for your continued service to our veterans.

I spent 5 years in a hot war in Southeast Asia as a naval flight officer (NFO), and after that was over, I came back to the States and went to college on the GI bill. And the first week I was back in the States—I had moved from California to Delaware, and the first week I was back, I got in my Volkswagen Karmann Ghia with a rebuilt engine, and I drove from Newark, Delaware, to a VA facility in Elsmere, Delaware, about 12 miles away. And I had my DD214 with me, and I presented it to the folks there, and I said, "I think I am eligible for some benefits." And they checked me out, and they said, "Yes, you are. And if you will come back in a week, you are eligible for some dental benefits. You can have a checkup." And a week later, I came back, met a fellow, a dentist named Jerome Kayatta, and he took care of my dental needs. And at the end of my visit, he said to me, he said, "This is not a very good health care facility. The morale is not good. The quality of the service is not good. If I were you, I think I would get my medical care from someplace else."

Ironically, 40 years later, he is still my dentist. He works part-time pro bono in the Delaware correctional system, providing dental care for folks that are incarcerated, some of whom are veterans. But I never thought of him as a whistleblower, but he did more to bring my attention to the need to make changes at that facility and health care provided for veterans all over our State. And I worked very hard to make sure that that was a hospital that we could be proud of, that they could be something closer to the gold standard than where they were in, gosh, 1973–74. And we have outpatient clinics—we only have three counties in Delaware, but we have VA facilities in all three counties. Do they provide perfect service? Absolutely right, no, they are not. None of us are perfect. But if you talk to the veterans in our State who use the VA, those outpatient clinics and our VA hospital—I call it the "mother ship" in Elsmere. I think for the most part they tell you that the people who work there are caring, dedicated men and women and dedicated to ensuring that veterans get the kind of service that they deserve. I would just sort of start off by saying that.

The other thing I would say, we have a big air force base in my State, Dover Air Force Base. We are very proud of the work they do. They are an airlift base, have C–17s and C–5 aircraft. They

travel all over the world every day, delivering people and cargo wherever it is needed.

They also have a special responsibility, Dover Air Force Base, because that is the mortuary for our country, and it is where the remains of our fallen heroes are brought throughout the year for years to Dover Air Force Base. It is a sacred mission. A sacred mission.

About a half dozen years ago, we heard from a whistleblower at the mortuary at the Dover Air Force Base that some of the practices and procedures there were inappropriate. Things were happening that should not have happened in the carrying out of their responsibilities, and it indicated that there was a problem of leadership, leadership at the military level, colonel, full-bird, and at the civilian level, top civilian level leadership. And there were some people who thought, well, this person is just a malcontent. Well, as it turned out, there were a couple more people who came and shared their experiences with us. Our congressional office got involved, the congressional delegation got involved, and the Office of Special Counsel got involved. And the Office of Special Counsel—I think there is somebody here today from the Office of Special Counsel. They did a very good job.

I once shared this with my colleagues. Two years ago, I was back—I go to the air force base a lot, but 2 years ago, I was back for a special visit and tour of the mortuary. I want to tell you, the hardest work I have ever seen anybody do in the military is in that mortuary, the people who deal with those remains and piece body parts back together. I mean, we think we have had tough jobs. Oh, my God, they have tough jobs, really tough jobs.

But I went back, and it was interesting. They had a whole delegation of civilian and military folks there at the entrance to greet me. And foremost, right at the front of the group was Mr. Z, one of the original whistleblowers. Surrounding him were the other whistleblowers. And they were there to welcome me back. And do you know who was not there? The full-bird colonel. He was gone. And you know who else was not there? The civilian leadership of the mortuary. They were gone. And you know who was still there? The whistleblowers.

So I just want to say sometimes whistleblowers were this Jerry Kayatta all those years ago in an unofficial role as a whistleblower, and more recently Dr. Z and the whistleblowers at the Dover Air Force Base. Sometimes—the parable of the seeds? Some of the seeds fall on the hard ground and in the thorns and so forth. Some of the seeds fall on fertile ground. In those cases, I think in Delaware, better things have happened.

So I just wanted to share that with you. I have a couple of questions for you. We will maybe have a second round here, but I wanted to raise that.

I also wanted to say as much as we appreciate your being here and look forward to hearing more from you today and I look forward to asking some questions, I just need to make a note that I have raised a concern of this at other hearings we have had for whistleblowers. I just think we need to respect the independent, objective process that Congress has set up in the Office of Special

Counsel, which I have alluded to before, the Merit System Protection Board, and elsewhere.

The last thing I want to say is this: Leadership. I wrote a note down here, and the Chairman looked at it. I wrote down the word "leadership." The most important element in the success of any organization I have ever been a part of is leadership. Whether it was a military unit, a VA facility, here, business, even a sports team, leadership is always the key. And the guy that the President nominated to be the leader of the VA a couple of years ago is a fellow who was a West Point graduate, a fellow who was a Ranger, and who understands the military from the inside out. And what needs to happen at VA facilities across the country is the quality of leadership that I think exists at the top needs to permeate and come down to the local level.

And I want to second again what the Chairman has said. We have sent many letters to this President saying we need more permanent IGs, Senate-confirmed IGs. And to the administration's credit, they have done a better job in the last year or two. And this IG has been vacant for almost 2 years. Way too long. We have had an opportunity to meet just in the last week or so with the current leadership of the Inspector General's Office acting person. We need permanent Senate-confirmed leadership, and I would just urge our Committee to continue to write to the administration again and again and again, call and say this is a problem, this needs to be addressed.

Thank you. I look forward to asking some questions in a few minutes. Thank you all.

Chairman JOHNSON. Senator McCain.

OPENING STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman. I want to apologize for not being here for the entire hearing. I am chairing a hearing in the Armed Services Committee at the moment. But I wanted to come up here to mention my appreciation for the witnesses. I thank you. I thank you for your courage. I thank you for your steadfastness. And this is a very important hearing, and I want to thank the Chairman for having it.

I also want to give a special thanks to Mr. Coleman. I want to thank him for his willingness to reach out to my office to share with me and my staff his experience at Phoenix as a whistleblower. We all know, Mr. Chairman, that this whole scandal began to unfold at the Phoenix VA where 50 of our veterans allegedly died because of a failure to receive—because of being on some kind of phantom waiting list.

I think, Mr. Chairman, from what I have briefed, that we are finding out that there is a viewpoint or an environment in the VA that discourages and even punishes whistleblowers. Is that your conclusion? Then I would just like to ask the witnesses one question. What can we do to better protect you and others who are willing to come forward and willing to risk their careers in order to get better treatment or even in some cases treatment for our veterans who, in the view obviously of the treatment in the past has been less than acceptable? Maybe I can begin with Mr. Coleman and

then you, Mr. Kirkpatrick, and then the others, Mr. Colon and Mr. Wilkes.

Mr. COLEMAN. Senator McCain, I just want to thank you and your staff. They are amazing, and you guys have been with me from the beginning, from the first letter you wrote to the Secretary, and I just wanted to thank you for that in person.

The word that comes to mind when you asked the question is "accountability." When there is wrongdoing committed, it does not matter if the VA employee is a janitor or food service worker or a hospital director. When they are caught doing wrongdoing and breaking Federal law, they should be fired. When these employees——

Senator MCCAIN. And to your knowledge, there is none of that?

Mr. COLEMAN. Senator McCain, the director had a meeting on the 13th of January asking to terminate me, was told he could not terminate me by legal counsel Shelly Cutts, and she said, "But we can come up with other employee actions to get rid of him." On the 27th, I was taken out of my position. The H.R. chief, Laurie Butler, came forward and gave a sworn deposition—she is also a retired Navy officer, has no reason to lie; I never met her before in my life—showing that this meeting happened. We have asked for a full investigation into Director Glen Grippen's actions. It is amazing, the corruption that goes.

So if you wanted an answer from me, my answer is accountability. When we catch these directors doing wrongdoing, they need to be fired, just like they do to us when we come forward.

Senator MCCAIN. And if they are not fired, then the leadership should be fired.

Mr. COLEMAN. I agree. I agree, sir, because how can you trust your commanders in chief, all the way up the chain of command. These are not people you are ready to run into combat with, because they are out for themselves. So, all of us here, the three of us are all veterans. And I believe in my chain of command, and I also believe in good leadership, as you guys were saying before. There is not good leadership currently. We do not trust the leadership, because look at what they can do to us.

Mr. KIRKPATRICK. I would second what Mr. Coleman said. I think, accountability for the people who have been proven to be the problem is certainly what should happen.

I also realize that this process here is a long, tedious one that requires gathering evidence, hearing testimony, as we are doing now. As I pointed out, the chief of staff at the hospital where my brother worked as far as I know is still employed by the VA, and it appears that he ran that hospital through intimidation, forced some good people out there—my brother, who really wanted to help people and sacrificed everything to be able to do that. It seems like the people who are the bad ones here, they lack that ingrained compassion and desire to help the veterans.

It is difficult for me because, I am not a veteran myself, and I am speaking on behalf of my brother, who cannot speak for himself, but——

Senator MCCAIN. Well, could I just say to you, sir, that I know this Chairman and I know the Ranking Member, and I want to support them every way possible. We will do everything we can to

hold them accountable. And what bothers us is that what happens to you is a strong disincentive for others to act with your courage. Is that right, Mr. Colon.

Mr. COLON. That is totally correct, Senator. And, first of all, I want to thank you for your service.

Senator MCCAIN. Thank you.

Mr. COLON. Like Mr. Brandon Coleman said and Mr. Kirkpatrick, there has been no accountability for the whole team that retaliated against me in San Juan, Puerto Rico.

Another thing that I find astonishing, there is a table of penalties from a center memorandum that is a VA directive that States on page 38 to 42 that they can remove people for retaliation. But they failed to use their own table of penalties to hold executives or managers or supervisors that are retaliating against whistleblowers. So I find the main key thing, I think, to fix everything is to hold people that are found guilty of retaliation to be removed from the VA.

Senator MCCAIN. Thank you.

Mr. WILKES. Senator, it is good to see you again. I know we talked when you were in Shreveport with Senator Cassidy, and you had told me—and I think this is very telling. You said to me that day, when I said I am one of the whistleblowers, you said, "Thank you." And you said, "Do you know that I sat in front of that director, and they looked me in the eye, and they said nothing was going on"? And, if they will lie to you and try to cover this up, there is no accountability, and they do not fear it. You can just see that they do not fear that anything is going to happen to them because they have gotten away with it for so long.

Until we are able to show that whistleblowers will be protected and that something is going to be able to be done, you are never going to know the depth of this corruption. There are people that want to come forward but are scared. They need their jobs. They come and they pull Brandon and me aside, and they say, "Thank you for coming forward." And then, some of the schedulers said, "Hey, you brought this forward, and, are they going to go back and change our evaluations?" And I said, "What do you mean?" They said, "Well, they marked us lower, and they told us, 'You made this many appointments over 14 days, and we are marking you down.'"

And I want to tell them, "Yes, they are," but I cannot because I know they are not. They want to come forward and say—they have told me, "I would tell the IG if they came and asked me." The IG does not want to ask them.

Senator MCCAIN. Well, I thank you, and I thank you, Mr. Chairman, and Senator Carper for this hearing and your untiring efforts. We have to stop this. We just must stop it.

I thank you, Mr. Chairman.

Chairman JOHNSON. Well, thank you, Senator McCain. And just to kind of answer your question in terms of how rampant, it is almost epidemic proportions, but in subsequent testimony by the Office of Special Counsel, she is laying out the facts, that there are 4,000 prohibited personnel practice complaints in 2015 to the Office of Special Counsel. Four thousand. That would be the retaliation complaints. Fourteen hundred of those, about 35 percent, come

from the VA. So this is rampant, this is a problem, and it is a problem we are going to address.

Let me just say we are going to have votes at 11, and I think what I will do, because the Ranking Member, Senator Carper, did not get a chance to ask questions, I will turn it over to him. He can ask questions. I would say, Senator Baldwin, if you would like to stay here and ask questions while I go vote—I am not going to recess. We will just keep this thing going. But then when I come back, we will seat the next panel. So if you guys want to take it from there and ask questions.

Senator CARPER. Thanks.

Chairman JOHNSON. And, again, thank you. I will be back.

Senator CARPER. Thanks.

Chairman JOHNSON. I heard there was one vote.

Senator CARPER. I think there are two.

Chairman JOHNSON. OK. That will complicate things. I will still quickly vote, and we will get going.

Senator CARPER. [Presiding.] OK, good. Again, our thanks to you. Please bear with us as we try to do our jobs here and do our jobs voting. Sometimes it gets a little complicated.

I believe one of the goals of this Committee needs to be understanding how the process really works for whistleblowers and what we can do to improve it.

I would just ask each of you just one thing that is working, one thing that is working that you have seen working with respect to whistleblowers, whistleblower protection, and share a best practice with us. And if the answer is, "I have never seen anything that works"—the Office of Special Counsel I am convinced works. We have seen it ourselves at Dover Air Force Base. But just share with me one thing, very briefly, one thing that you have seen work. And I do not care who goes first.

Mr. WILKES. With me, the Office——

Senator CARPER. I like to say: Find out what works. Do more of that.

Mr. WILKES. I think you are right. The Office of Special Counsel helped me. I would probably still have a looming criminal investigation over my head today if they had not stepped in when I filed my——

Senator CARPER. OK. Thank you.

Mr. COLON. I just wanted to say one thing. I think it is the Office of Special Counsel—if it was not for the Office of Special Counsel, I would have been terminated. I think they worked. That is why I think we have to give them broader authority to hold these people who retaliate against us. And I would say just the Office of Special Counsel.

Senator CARPER. All right. Thank you, sir. Mr. Coleman.

Mr. COLEMAN. Senator, I would echo their statements with the Office of Special Counsel when I came forward. What I would say is they need more help. The Office of Special Counsel I believe is overwhelmed, because I get, just like Dr. Katherine L. Mitchell, one of the whistleblowers from 2014, she and I speak just about every day, and I get anywhere from one to three calls from whistleblowers. I have had two since I have been in D.C. where I listen to these employees cry and tell me what is going on, and I always

take that call, because I wish someone would have been able to do that for me.

So I believe that the Office of Special Counsel needs more help, because I think some of these people that are coming forward, I just think it is an overwhelming task to ask the Office of Special Counsel to be able to help everybody. I do not think they have the manpower currently.

Senator CARPER. All right. Thanks so much. Mr. Kirkpatrick.

Mr. KIRKPATRICK. Unfortunately, I do not have the status of being a whistleblower myself, so I cannot really confidently comment on that. But I would say with the people that I know and have met, Ryan Honl, Noelle Johnson, and others, I think—and I know this may not be the answer you are looking for, but, they found sympathetic people within the media. They reached out to other whistleblowers, and as I stated before, I would not know any of what happened to my brother without Ryan and Lin, and that is really all I can say about that, and this Committee as well.

Senator CARPER. Thank you.

Mr. KIRKPATRICK. Thank you.

Senator CARPER. Let me just ask, for those of you who are whistleblowers, when you first thought you were being retaliated against, were you aware of your rights as a whistleblower and the processes and resources that were available to you? Mr. Wilkes, would you start with that?

Mr. WILKES. I had taken the trainings, and I was somewhat aware of it. But the overall process and how to do it and things like that, I have had to figure out on the go, who to file with, what you can file. A lot of times when you have a complaint in the VA, what I found is that you want to say, "Hey, let us go to EEOC," or, "Hey, let us go to Office of Special Counsel," or, "Hey, let us go to the IG." I went to the IG first because I thought that is what to do. I never heard from them on the first one I did, and then the second one, it took them a month and a half after I reported it again.

I went to the Office of Special Counsel after they told me that I was under investigation criminally, and I learned about that process. So I was not aware—it is a lot of steps to it, and that is kind of why we kind of started a support group, the Truth Tellers and stuff, to kind of help each other and share our stories with each other to let each other know exactly how to file, what you want to make sure, I mean, because it is very emotional, and you are isolated. I mean, they isolate you, and that is how they kind of keep you that way.

Senator CARPER. All right. Thank you.

Mr. Colon, same question, please. Were you aware of your rights as a whistleblower and the processes and resources available to you?

Mr. COLON. Negative, sir. But I was well aware that once I came forward that I would be retaliated against, because I had a good friend in 2010 that came forward about the reusable medical equipment that happened down in San Juan, Puerto Rico, and he was removed from his position. I do not think there is enough training of it. I know the American Legion visited our facility, and they

found a bunch of posters that were up in the office that were never posted.

When people come talk to me, I am very honest with them. I tell them, "If you are willing to come forward, expect this to happen," because as long as—like, I keep on reiterating this famous word—there are two words, and I do not wear the "I Care" pin for two reasons, because I am an advocate, he is an advocate, he is an advocate for veterans, and we have become—look what they have done to us. And then they do not use the "A" for the accountability. So I will never wear that "I Care" pin until I see actual change. But there is nothing. They do not tell you how to do this. It is like the other fellow, a friend over here that just stated there is no training for us from the get-go.

Senator CARPER. OK. Thanks. Mr. Coleman.

Mr. COLEMAN. I think, sir, even the training that there is limited, and it has changed so much in the last 2 years since this scandal has been going on.

I think one thing that is important to point out is that we as whistleblowers, we should have the right to defend against retaliatory actions before the VA goes on the witch hunt. That is from the time that I came forward to the Office of Special Counsel regarding the systemic issues in early December, and then the retaliation was nonstop. However, the Office of Special Counsel was unable to take action until I was walked out from my employment on January 27th, crying. I had no one to call. I called the OSC attorney, David Tuteur, literally in tears. I did not know what to do, because I had just been taken out of a job that I loved. So, there is no way to defend ourselves, and the OSC, their hands are kind of tied as far as the retaliation goes until an act like that occurs, the overt acts of retaliation are going on every day. I asked for mediation on November 26th, because that is what I was told to do. My direct-line supervisor, who retaliated against me, waited until December 16 to get back to me, 20 calendar days. I know that is not right. It is my full written 188-page testimony that you have, sir.

Senator CARPER. All right. Thank you. Some of you have already answered this question, but I just want to throw it out there anyway. Based on your experience—and if you have already answered it, you do not have to answer it again. But based on your experience, what do you think could be done to make the information about whistleblowers' rights and the processes and resources available to whistleblowers, what could be done to make the process work better for future whistleblowers? And if you have already answered that, that is fine. But if you have just a nugget or two you would like to share with us, please do.

Mr. COLEMAN. I think I would like to share on that, Senator, if I could. I think that not enough is being done to get the word out, and I do not know what the answer is, because I have thought about this. I enjoy helping veterans get clean and sober. That is what I think I was put on this Earth to do professionally. It is just amazing.

Senator CARPER. Isn't it great to know what you were put on this Earth to do? Isn't that great?

Mr. COLEMAN. It is, and to actually get paid for it, that is the trick having a job you would do for free.

However, I would say that I am very passionate about whistleblower rights, and it has kind of grown just because of what I have been through. I think more needs to be done. I do not think we can count on the VA to have us set up, but I think groups like the Truth Tellers, having ways to have whistleblowers available, because like I said, just getting these calls, these calls from other whistleblowers, is just heart-wrenching. And they have nowhere to go. And I am telling them to contact certain Senator or Representative's offices, sometimes out of their home State, because I have developed relationships with them, and I am telling them which media outlets to contact because the media is kind of your best friend in defending yourself. If it was not for the media and the Senate offices and the OSC, I would have been fired long ago? And so you kind of have to fight that battle, and each one of our battles, while they are so similar, are also so different, because like Shea—like Mr. Wilkes said, we are isolated. They isolate us. I had read all the articles from Tomah and, from Shreveport and from Puerto Rico, and I knew these guys existed. But I never knew that they went through the same thing as me, and that is where the power is, us coming together to be able to help future whistleblowers. There needs to be help there until we figure out a way to fix the VA. I do not know how long that is going to take, but there needs to be more to protect these people under Federal law when they are brave enough to come forward. That is what I think, sir.

Senator CARPER. Yes, the media can play a valuable role here. The media takes a lot of abuse. They hand out a lot of abuse.

Mr. COLEMAN. They protected me.

Senator CARPER. But they also can play a very valuable role here.

A real quick one, if I could, for Mr. Wilkes, and then the Chairman is going to come back and I am going to run over and vote, and we will play tag. I understand you are the founder of the group VA Truth Tellers. Could you just take a minute and explain to us what motivated you to get it started and how does it work?

Mr. WILKES. Basically it took off on its own. I kept reading, like Brandon said, these articles, and I am, like, "Oh, my gosh, this is going on to a lot of us all over the country. And, like Dr. Mitchell and her thing, she had said that the IG was more worried about her making privacy things, and that was like me. They were more after me, investigating me for privacy violations.

And I just started reading stories, and I reached out to Brandon and actually a lot of the media. And he is correct. The VA is more worried about their image, and that is one way that you can get the attention, is to try to tarnish their image and get your story out. And, actually, a lot of the media reporters got me in touch with all them, gave me their email addresses, gave me their phone numbers, and we started reaching out. And I had four. And then I met Germaine Clarno, and she had been trying to do the same thing on the other side. And it started out, we had 10 people, and basically it was in email. We were emailing just supporting each other.

And, it kept growing, and people started coming in, and I was, like, "Oh, my gosh," I did not expect it. And then we knew we had something. And then when those reports came out in Tomah and

we had seen it and they whitewashed them and they started attacking whistleblowers, we had had enough. And I told the group and Germaine and I told them, I said, "We got to do something about this." And then that is when we came out with the letter to the President about, the IG Director at the time we were calling for him to be dismissed. And that afternoon, after that letter, he announced his retirement that Saturday. And since then, it has kind of grown even more. I mean, every day Brandon—I get emails, text messages from whistleblowers all over the country and it is the same thing. It is the same story. It is absolutely amazing how each of our situations are unique, but how the retaliation is so similar. It is like the VA leaders have a book they developed on how to retaliate and this is how you do it, because it is the same.

Senator CARPER. Over the last, gosh, 40-some years, maybe 50 years, in this country we have tried to figure out in a health care delivery system how do we get better results for less money, and for years we kept seeing the percentage of health care costs in this country as a percentage of GDP go up, up, up, up, double-digit increases in the rate of inflation in health care delivery, and not always with better results. A couple years ago, we had a situation where it was widely reported that about 100,000 people died in hospitals every year. It is not VA hospitals, but like hospitals across the country, which is a sad commentary. It is a sad commentary. Some people said we need to do health care reform in order to slow the growth of health care costs, and we did. Some people said we needed to do it in order to better ensure that we do not have 40 million people that go to bed at night without any health care coverage. We did. And we also said we had to get better results, and we do. And I think in some respects we are. The number of people without health care coverage is down from about 40 million to maybe closer to 10 million now, headed in the right direction. Health care costs as a planning of gross domestic product (GDP) is no longer going up double-digit rates of inflation. In fact, health care costs as a percentage of GDP are actually coming down now slightly. But we still have a lot to do in terms of getting better results for less money.

I am going to run and vote; otherwise, I miss my chance. But I will be back, OK? Thank you. Thanks, Mr. Chairman.

Chairman JOHNSON. [Presiding.] Thank you, Senator Carper.

Again, I want to thank the witnesses for taking the time coming here, and let me underscore again that our ability—and you are seeing, I think, some bipartisan agreement, which is really what we need to do. Let us concentrate on the areas of agreement that unite us rather than exploit our division. So you are seeing some bipartisan agreement. Our ability to take action, to pass legislation, will be due in large part because of the courage of your actions and the power of your testimony.

So, again, I want to thank all of you for coming forward. Obviously, we offer our condolences, Mr. Kirkpatrick, to you and your family. But, again, thank you for coming forward. We will act. We will act.

Thank you. Let us seat the next panel now.

[Pause.]

Thank you. I appreciate your patience.

As I said in the earlier panel, it is the tradition of this Committee to swear in witnesses, so if you will all rise and raise your right hand. Do you swear that the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. LERNER. I do.

Ms. HALLIDAY. I do.

Dr. CLANCY. I do.

Mr. CULPEPPER. I do.

Chairman JOHNSON. Thank you. Please be seated.

Our first witness on the second panel will be Carolyn Lerner. She is Special Counsel at the Office of Special Counsel. Ms. Lerner.

TESTIMONY OF THE HONORABLE CAROLYN N. LERNER,[1] SPECIAL COUNSEL, U.S. OFFICE OF SPECIAL COUNSEL

Ms. LERNER. Thank you, Chairman Johnson, Ranking Member Carper, and Members of the Committee. Thank you for the opportunity to testify today about the U.S. Office of Special Counsel and our work with VA whistleblowers. I also want to thank you or your work founding the Senate Whistleblower Caucus. OSC has already started to work with this caucus and looks forward to doing so more in the future.

The Office of Special Counsel helps whistleblowers, and helps employees who make disclosures of wrongdoing and those who experience retaliation after doing so. There are separate processes for these two types of cases. I just want to go over them briefly.

If an employee discloses a health or safety concern or a violation of law, rule, or regulation, and it meets a very high standard of review, I send the matter to the agency for investigation. After investigating, the agency must then provide an investigative report to my office. The whistleblower is given an opportunity to comment. I then determine whether the agency report contains the information required by statute and also whether the agency's findings appear reasonable. This includes whether appropriate corrective action, including discipline, has been taken. I then send the information and our findings to the President and Congress and post them on our website. That is the process for disclosures.

OSC also protects Federal workers from prohibited personnel practices, especially retaliation for whistleblowing. Unlike disclosure cases where we do not have independent investigative authority, in retaliation cases OSC conducts the investigation and determines if retaliation occurred. We can get relief for the employee, including a stay of disciplinary action, reversing a termination, and damages for losses that are suffered as a result of the retaliation. So that in a nutshell is our process for we believe disclosures and retaliation complaints.

Over the past 18 months, there has been a tremendous surge in cases from the VA. I will talk now about how our agency is addressing them, some signs of progress, as well as some areas of ongoing concern.

OSC has about 140 employees with jurisdiction over the entire Federal Government. We are stretched pretty thin. But we have re-

[1] The prepared statement of Hon. Lerner appears in the Appendix on page 97.

allocated our resources to prioritize VA cases. Perhaps most significantly, we implemented an expedited review process for retaliation cases. This process allows OSC to present strong cases to the VA at an early stage, saving resources and getting quicker relief for employees.

In the past year, we have obtained approximately 30 corrective actions for VA whistleblowers through this expedited process, including a settlement on behalf of Mr. Joseph Colon, who testified just now. We also worked to secure relief for Mr. Ryan Honl of the Tomah VA.

These are important victories for employees who risk their professional lives to improve VA operations and quality of care provided to veterans. My written testimony summarizes a number of other cases resolved through the expedited program, including an employee who was fired for requesting assistance from Congress.

It is a sign of progress that the VA leadership agreed to the expedited review process. It has also agreed to resolve many more cases through regular processes, including mediation, through which we have gotten VA employees full or partial relief 84 times this year.

On the disclosure side, our work has led to important improvements at the VA as well as discipline for 40 officials. This is an important step toward greater accountability and deterring future misconduct. However, our review of several recent disclosure cases indicates that disciplinary actions are being inconsistently imposed and are often of little consequence. The failure to take appropriate discipline where there is clear evidence of misconduct can undermine accountability, impede progress, and discourage whistleblowers from coming forward.

I highlighted these concerns last week in a letter to the President and the Chairmen of the VA committees. I believe you all have that letter now. In the letter, I contrasted the lack of discipline in response to confirmed mismanagement at the Phoenix VA and other locations with the penalties imposed on whistleblowers for minor indiscretions. For instance, one whistleblower faced termination for eating a few expired sandwiches worth $5. I hope that VA leadership will review these cases and determine whether systemic changes to discipline could correct the inconsistent imposition of penalties.

Based on the VA leadership's positive responses to prior recommendations, I am hopeful that they will work to address this problem. In fact, just last week, Deputy Secretary Sloan Gibson outlined a new process for responding to OSC whistleblower referrals. They will now be routed through the VA Executive Secretariat. This should ensure high-level review of all whistleblower allegations and investigations, and I am hopeful that the centralized process will help to address the concerns I outlined in my September 17 letter.

Other ongoing issues of concern which I have previously noted include retaliatory investigations of whistleblowers, improper accessing of whistleblowers' medical records, the role of regional counsel, and the VA IG's unwillingness to provide OSC with information.

In conclusion, we appreciate the Committee's interest in our efforts to protect VA whistleblowers and for all you are doing to ad-

vance whistleblower rights. The stories we have heard today from the four witnesses on the first panel are the stories that we hear every day at the Office of Special Counsel from hundreds of VA employees. We appreciate your support for our efforts.

Thank you for the opportunity to testify, and I am happy to answer any questions you may have.

Chairman JOHNSON. Thank you, Ms. Lerner.

By the way, I think that is an extremely important point that we just had four stories but they are typical.

Ms. LERNER. Hundreds.

Chairman JOHNSON. They are not outliers. This is what you are dealing with, so I appreciate your efforts.

Our next witness is Linda Halliday. Ms. Halliday is the Deputy Inspector General at the Department of Veterans Affairs Office of Inspector General. Ms. Halliday.

TESTIMONY OF LINDA A. HALLIDAY,[1] DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. HALLIDAY. Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the fundamental importance of whistleblowers to the VA OIG's mission and how the OIG works to protect and encourage Federal employees to come forward with allegations of waste, fraud, abuse, and mismanagement. I am accompanied by Mr. Quentin Aucoin, our Assistant Inspector General for Investigations.

Whistleblowers are the lifeline of OIG organizations. Our OIG is committed to protecting their identities, understanding their concerns, objectively seeking the truth, and ensuring VA pursues accountability and corrective action for wrongdoing. Individuals who at times risk their reputations and careers to report suspected wrongdoing should be afforded all the protections available by law.

Whistleblowers have played a vital part in revealing serious problems in need of corrective action at VA. For example, we recently acknowledged the instrumental efforts of whistleblowers who exposed extensive, persistent data integrity issues at the VHA's Health Eligibility Center and serious mismanagement and operational performance issues at the VA Regional office in Philadelphia.

Federal laws dictate that veterans have both a right and an expectation that VA employees will not compromise the security of their sensitive personal information, even during the course of making a whistleblower disclosure. While we strongly encourage the reporting of wrongdoing, we equally encourage employees to do it in a responsible manner consistent with the applicable laws.

After assuming the position of the Deputy Inspector General 3 months ago, I made it my first priority to reinforce that the OIG values whistleblowers and that we are hearing and learning from the more recent complaints. We go to great lengths to protect their identity. We encourage them to report suspected wrongdoing to the IG. And any reprisal for doing so is absolutely unacceptable.

I took steps to strengthen our Whistleblower Protection Ombudsman program and our internal whistleblower training program.

[1] The prepared statement of Ms. Halliday appears in the Appendix on page 110.

OIG is also in the process of completing the U.S. Office of Special Counsel certification program which will ensure that all OIG employees can assist complainants in educating them on their right to be free from retaliation for whistleblowing.

But our efforts to improve the OIG business processes and encourage whistleblowers to come forward do not stop there. I have also directed my staff to assess our own communications and feedback with individuals who report suspected wrongdoing, especially when the complaints involve complex and lengthy reviews, and to take action to update with VA their current policy on managing external referrals to VA. We are assessing opportunities to change our existing process for referring lower-risk complaints to VA that we lack the resources ourselves to do, to include assessing the feasibility of repositioning our resources to perform more reviews with our own resources rather than relying on a process that makes external referrals to VA. We want to provide greater assurance of confidentiality to whistleblowers and to enhance the quality of our own investigations and reviews performed.

I have also reinvigorated the OIG rewards program, but make no mistake about it: We recognize the critical role complainants and whistleblowers play in exposing serious problems and deficiencies in VA programs and operations, and I will continue to review and evaluate ways in which OIG can enhance its interactions with complainants and promote greater confidence.

In addition, I have done outreach to meet and establish strong relationships with several of the large Veterans Service Organizations to enlist their input on programs that may not be serving veterans' needs well. While we are thankful that the Congress has facilitated growth in OIG resources, I want to conclude by leaving the Committee with the understanding that there is a serious discrepancy between the size of our workforce and the size of our workload. The OIG is not right-sized to respond to all of the complaints we currently receive. We have approximately 660 multidisciplinary professional staff conducting criminal investigations, audit, health care and benefits inspections, and contract and financial reviews for an agency with more than 354,000 employees and $163.5 billion in their operating budget in Fiscal Year 2015. In fact, OIG's Fiscal Year 2015 budget is less than 1 percent of VA's budget. The resources pale in comparison to VA's massive decentralized and diverse facilities and the number of employees and the amount of funding needing regular oversight.

Mr. Chairman, this concludes my statement, and I would be happy to answer any questions.

Chairman JOHNSON. Thank you, Ms. Halliday.

Our final witness is Carolyn Clancy. Dr. Clancy is the Chief Medical Officer at the Veterans Health Administration within the Department of Veterans Affairs. She is accompanied by Mr. Michael Culpepper, the Acting Director of the VA Office of Accountability Review. Dr. Clancy.

TESTIMONY OF CAROLYN CLANCY, M.D.,[1] CHIEF MEDICAL OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL CULPEPPER, ACTING DIRECTOR, OFFICE OF ACCOUNTABILITY REVIEW

Dr. CLANCY. Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting us here today to discuss the ways that Congress and VA can further encourage Federal employees to come forward with their concerns regarding quality of care, patient safety, and waste, fraud, and abuse.

We exist at VA to serve veterans, and we depend on our frontline employees to serve veterans with dignity, compassion, and dedication. And I want to thank you and the Members of the Committee and other colleagues for recognizing just how passionate and dedicated the vast majority of our employees are.

We depend on these same employees to be vigilant about actual and potential sources of harm to patients and to voice their concerns if a patient's safety is at risk. We recognize very clearly the important role that whistleblowing plays and addressing the express concerns in bringing issues to light.

As the whistleblowers today have demonstrated, the Department has had problems with ensuring that whistleblower disclosures receive prompt and effective attention and that the whistleblowers themselves are protected from retaliation.

Secretary Robert McDonald, Deputy Secretary Sloan Gibson, and other VA senior leaders, including myself, have made it our practice to meet with whistleblowers when we travel to VA facilities and to engage directly with those who have raised their hands and voices to identify problems and proposed solutions.

For example, I am personally invested in ensuring that the quality of care at the Tomah VA is of the highest order and that any and all circumstances that led to problems at that facility have been diagnosed, addressed, with a sustainable path forward.

Retaliation against whistleblowers who have demonstrated the moral courage and at great personal risk to share their concerns is unacceptable and cannot and will not be tolerated. We are making progress, and under Secretary Robert McDonald's leadership, we are confident we will reach our goal of ensuring that every employee feels safe in raising concerns and is protected from retaliation when they choose to do so. Monitoring the environment and whether people feel safe speaking up is something that we watch very, very closely.

All health care systems require a wide array of feedback from multiple sources to ensure the best clinical outcome for patients. In addition to many formal mechanisms, the Department has taken several important steps in recent months to improve the way we address operational deficiencies and to ensure that those who disclose such deficiencies are protected. For example, we have communicated regularly to employees and managers about the importance of whistleblower protection. We track corrective actions, require annual training, and we have an online way to gather employee feedback and are now certified by the Office of Special Counsel.

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[1] The prepared statement of Ms. Clancy appears in the Appendix on page 117.

In addition, just over a year ago, the Secretary reorganized and assigned new leadership to VA's Office of the Medical Inspector (OMI). OMI moved quickly to establish clear policies to ensure that whistleblower allegations are investigated objectively, thoroughly, and promptly. Since that time, this office has completed 30 new whistleblower investigations and prepared more than a dozen supplemental reports to follow-up on earlier investigations.

We have also improved our collaboration with the U.S. Office of Special Counsel, to step up to the challenge before us. We have collaborated with OSC to design and implement training for VA General Counsel and the Office of Accountability Review (OAR). This will eventually be rolled out across the Department, and as has been noted, last summer VA and OSC agreed upon an expedited process to speed corrective action for employees who have been subjected to retaliation. As of September 9, we had received 22 expedited cases and resolved 11.

We understand that we can improve on the timeliness of ensuring individuals found responsible for retaliation are disciplined appropriately and that deficiencies with programs and underlying issues are addressed.

One approach that we do want to raise is for Congress to fund OSC at a level that enables that office to hire more investigators to complete this work. OSC has traditionally fulfilled this charge, and increasing their staffing to a level to assist VA in this endeavor would allow VA's limited investigative assets and resources to focus more in our area of expertise.

To say it a different way, if we are successful in encouraging whistleblowers to step forward, we will have many more to deal with, and that is a good thing. That means that the people who are now currently fearful of stepping forward, as we heard from the first panel, will indeed feel that it is not only OK but a really great thing that they step forward and share their concerns. And it is anticipating that future that makes us raise this suggestion. It is very important that we hold individuals guilty of retaliation accountable for their actions and that we do so as timely as possible. And we welcome OSC's additional assistance on this front.

The courageous and really heroic witnesses you heard from earlier today, and many, many others, underscore the importance of ensuring that all veterans receive the highest quality of medical care. I acknowledge today that VA is still working toward the full culture change we must achieve. We need to listen better the first time employees raise concerns. We need to ensure that all employees feel safe disclosing problems, and we need to guarantee that all supervisors who engage in retaliatory behavior are held promptly and meaningfully accountable. And, last, we need to work on establishing a culture where everyone recognizes that whistleblowing is not only beneficial, it is a gift to the organization.

We continue to work with whistleblowers, OSC, and the Congress to resolve these issues and are very committed to these endeavors.

Mr. Chairman, that concludes my testimony, and we look forward to your questions.

Chairman JOHNSON. Thank you, Dr. Clancy.

Now, you were all three sitting in the audience for the previous testimony, correct?

Dr. CLANCY. Yes.

Chairman JOHNSON. I just want to ask each of you—and I guess we will start with Ms. Lerner—what was your gut reaction? What was going through your head? I mean, outside of your testimony, as you were listening to that testimony, what was going through your head? What was your initial reaction? Ms. Lerner.

Ms. LERNER. I wish I could say that it was news, but it was not. As I said in my opening statement, the stories, several of them we have been working with, so we are very familiar with these gentlemen's stories. And as you said, they are not atypical. These folks are representative of the hundreds of VA employees who come to the Office of Special Counsel. We have hundreds of matters just like that that we are dealing with now.

I think you may have been out voting when Senator Carper went down the line and said, "What can we do? What is working?" And each one of them said, I was very pleased to hear, that the Office of Special Counsel had helped them. So I was proud of that. I am really proud of my staff. Many of them are here today. They are doing, the Lord's work, really. They spend time on the phone with these folks who are in crisis, and they are doing an excellent job putting together reports of investigation that allow us to report to you and the President what is going on.

We are building cases, which together are sort of—not to mix metaphors, they are all parts of the puzzle that we can see what is going on all over the country. And so my recent letter said, look, this is a pattern that we are seeing everywhere. We are seeing folks getting slaps on the wrist who are engaging in serious misconduct, not really being disciplined, all over the country. Compare that with the folks who are taking sandwiches or, sending out one email about doing taxes. They are facing termination. There is something wrong here.

Chairman JOHNSON. Thank you again. I just wanted your initial reaction.

Ms. LERNER. Sorry. It was a long answer.

Chairman JOHNSON. Ms. Halliday, again, just initial reaction.

Ms. HALLIDAY. My initial reaction is I am really disheartened that VA is in the state of affairs it is in today. I have dedicated my entire career to serving veterans. The fact is if somebody brings an issue forward that can move positive change, why you would take actions against that individual is beyond me. When you do that, it is bad management.

Chairman JOHNSON. OK. Dr. Clancy.

Dr. CLANCY. Profound appreciation for the individuals who were here before and the work they are doing to support others. A lot of pain listening to Mr. Kirkpatrick talk about his brother. And continued concern personally about the people who are fearful of speaking up even as we sit here today. And, frankly, a lot of impatience. We need to speed up our actions in terms of our disciplinary processes.

Chairman JOHNSON. OK. I appreciate those answers.

Ms. Halliday, you heard Mr. Wilkes in his testimony say that the VA Office of Inspector General is a joke. In your testimony, you

said whistleblowers are a vital part, the Office of Inspector General values whistleblowers, reprisals are unacceptable. I want to talk about a white paper that was issued on really the investigation of this Committee and really the events that were revealed through press reports with the Tomah VA health care facility.

Were you at all involved in the writing of that white paper?

Ms. HALLIDAY. I was not.

Chairman JOHNSON. Were you aware it was being written and issued?

Ms. HALLIDAY. I was not.

Chairman JOHNSON. It strikes me as, quite honestly, reprehensible. We issued a subpoena to the Office of Inspector General because we were not getting cooperation in this Committee's investigation of the events at Tomah and, quite honestly, as that blossomed with other whistleblowers, what is happening around this country in terms of opioid overprescription, drug diversion, retaliation, and we were not getting cooperation under the previous Acting Inspector General, so we had to issue a subpoena at the end of April.

Now, the Office of Inspector General then issued this white paper a little more than a month later. Now, this is the same Office of Inspector General that basically deep-sized 140 reports and an Office of Inspector General that was so concerned, as am I, as is this Committee, about not releasing personal information, particularly health care records. And yet the Office of Inspector General issues this white paper, and I want to quote some of the more outrageous parts of this white paper. And this speaks, first of all, to the family of the Kirkpatricks.

This is from the white paper: "I strongly recommend a thorough review of the in-depth sheriff's report, a publicly available document that is included in the documents produced, records produced"—pages whatever—"with specific attention to the pages detailing the voluminous amounts and types of marijuana and what appears to be other illegal substances found in Dr. Kirkpatrick's residence, as well as other items including a scale and used devices containing marijuana residue."

I want that to sink in. This came from the Office of Inspector General who says whistleblowers are a vital part, the OIG values whistleblowers, reprisal is unacceptable. That sounds like a reprisal to me to a dead person. I want that sinking in.

Second, in referring to another whistleblower, pharmacist Noelle Johnson said her termination was because she had poor interpersonal skills and was caustic with clinicians. Again, this is a white paper from the Office of Inspector General. I can only conclude from this white paper—by the way, this was also directed to this Committee's investigation, but I could care less. But I care deeply about the intimidation, the retaliation, the reprisal coming from the Office of Inspector General.

So, listen, I appreciate the testimony. I appreciate the assurances that whistleblowers are a vital part, that the OIG values whistleblowers, that reprisals are unacceptable. But that is not the record.

What will the Office of Inspector General, what will the VA do to make good on this, to make up for this reprisal, for this reprehensible reprisal? What action are you willing to take? And you

heard Mr. Sean Kirkpatrick asking for the records for the family so that they understand what is happening. I want assurances that the VA will release those records to the family. I want assurances that this will be corrected, that amends will be made for this reprehensible reprisal. Ms. Halliday?

Ms. HALLIDAY. As I stated, I did not prepare that document.

Chairman JOHNSON. Who did? Do you know the individuals within the Office of Inspector General that wrote this? Who did this? I want to know. This Committee wants to know who is involved in this.

Ms. HALLIDAY. The prior——

Chairman JOHNSON. I want to know every individual who was involved in writing this report.

Ms. HALLIDAY. I would have to take that for the record.

Chairman JOHNSON. We will leave that as an open question for the record.

Dr. Clancy, what can the VA do to make amends for this?

Dr. CLANCY. I noted very clearly a number of very important suggestions that Mr. Kirkpatrick made, including the personal request about receiving his brother's official personnel file. I do not know and my colleague is not clear on whether we can do that, but if we can, we will certainly do so.

Chairman JOHNSON. OK. Listen, let me apologize for showing such passion up here. Let me tell you what my gut reaction was in this hearing to these witnesses. I was upset coming in here, and you can tell I have become more upset. I think every member of this Committee has become more upset as we hear this.

Ms. Lerner, you look like you want to say something.

Ms. LERNER. The only thought I have is possible disciplinary action that might be taken against the person who is responsible. That is, I think, an avenue that could be explored.

Chairman JOHNSON. Well, I will work with your office to find out exactly who those were and exactly what the proper accountability and the proper disciplinary action should be taken from those members in the Office of Inspector General, remember, that transparent, that independent watchdog over these agencies. My time has expired. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

First, a comment. On the situation in Tomah the Chairman has just discussed, the IG's various publications, I want to state for the record a conversation that we have had in delegation conference calls as well as private meetings on the importance of making VA' investigation into Tomah public. You can tell, by this hearing and the many other opportunities we have had to receive testimony that we have a greater ability to ask questions when we have a document we can read. I know you are working on that, but certainly we are very eager to see the work product; you have given us verbal assurances that you have spoken with each and every whistleblower whose name I have forwarded.

Beyond Tomah and looking more globally, I have two questions. One relates to the testimony we heard earlier and what I have heard from whistleblowers at Tomah concerning the ability of veterans to look into medical records and use what they have found to publicly assail the credibility of a whistleblower.

Based on the testimony that we are hearing, not only is this prevalent, but it sounds as though there have been virtually no instances of accountability for inappropriate access of those records. You have heard some fairly basic suggestions for how to make that right. One suggestion was that two parties have to be involved in accessing a record; another that we use information technology to uncover inappropriate access; and, third, that the folks who inappropriately access this data be held accountable. And I have not heard much of that.

I would like to hear your comments on tangible things that we can do to put an end to this. It seems to me one of the more simple things that we can address in all of this.

The other question I want to put out there—the testimony that we heard earlier suggests that it is really easy to fire somebody who is a whistleblower and really difficult to fire somebody who is the subject of a whistleblower complaint, to oversimplify the process. And the one thing that I want to make sure is, as we make it easier for the VA to hold people accountable, that we also do not make it easier for the VA to terminate the employment of those courageous individuals, some of them temporary employees or probationary employees.

Those are two big questions I want to ask, especially with this illegal access to veterans' medical records in the context of whistleblowing. This seems like a straightforward fix. I would open it up to you to respond.

Dr. CLANCY. So as Senator Ernst said very clearly, it is illegal to do that. It is also painful to hear about, particularly when the issues related to discrediting a whistleblower around the issue of having sought care for mental health problems, if for no other reason than the stigma and the very fact that someone who works for us would be using that to discredit someone else at a time when we recognize that as a huge barrier to reaching all the veterans who need to be reached, is very painful for me to hear.

Right now, veterans who are employees and use our system, as one of the earlier witnesses noted, their records are flagged. So there is no mistake if I stumble into a record of somebody with the same last name. This is not subtle. I am going to bring back and we will look into the issue of a two-step process. That seems to me to be potentially promising. But beyond that, it cannot be done, that is all, and it has to be—we can also track who accessed those records.

Ms. HALLIDAY. One of the challenges for the OIG is when information is inappropriately accessed, we always try to ensure the veteran's information is protected first, regardless of whether this is a whistleblower or an individual. In many of the cases that we have discussed and some of the cases that I have gone over the past year, veterans' information has been put at unnecessary risk for using outside systems to process veterans' personnel information and those inappropriate access to it.

So I would think that a control that allows for a dual signature for when a medical record is being accessed would be very appropriate based on the need to have that information associated with doing their job.

The second thing is the underlying controls within VA's system have to have the audit trails turned on, or you really cannot identify clearly who touched the record. And throughout many of the OIG reviews, we have found that key audit trails were turned off. They were turned off in Tomah. They were turned off in Phoenix. And we have told Office of Information Technology (OIT) officials they have to be on. You cannot monitor these 100 percent of the time. There is some responsibility for the Department to make sure those trails are in place. You just have to have that in this day when people can get access to records.

Ms. LERNER. If I could just add a couple of things. In February, I first notified the VA that it needed to consider a systemwide corrective action to avoid these types of breaches. Through our disclosure process, 12 employees have been disciplined as a result. We have pending investigations in multiple cases where this is a problem. The VA's position that we have heard so far is that the searches were justified because they were just getting demographic information, things like mailing addresses from the files. Even if that is the case, the system is broken, and it should be a fairly easy fix. All they really need to do is make it harder to access these medical records, put a better lock on the system. Doctors need to have access to medical records, but colleagues and co-workers should not.

The second thing is they are storing information right now so that medical information is commingled with demographic information. They are using the VistA system for both medical and personnel information, and that seems to me to be a pretty easy fix as well.

Chairman JOHNSON. Thank you, Senator Baldwin. I just want to quickly follow-up. Isn't there an easier place to get addresses other than from medical records?

Ms. LERNER. Well, they have a system for employees who are not also using the system for medical care, so you would think they could just use that system.

Chairman JOHNSON. I mean, there is an alternate system you can get addresses from, which if you are looking for an address, you go to that system.

Ms. LERNER. One would think.

Dr. CLANCY. There are many systems, and, in fact, right now there is a group pushing hard to get one reliable source so that we have contact with all veterans, period.

Chairman JOHNSON. My point is that excuse I would term a lie. Senator Carper.

Senator CARPER. I want to thank all of you for joining us today. Carolyn, I do not know if you were in the audience when I talked about the whistleblowers at Dover Air Force Base and the great job that you and your team did there making sure that we found out the truth. And what do they say? The truth will make us free. As it turns out, you guys played an invaluable role, and we are grateful for that. I do not know if you were here when I asked the first panel maybe what is working and what we should do more of; find out what works and do more of that. And almost everybody mentioned the work that is being done in the Office of Special Counsel.

Ms. Halliday, thank you for stopping by and visiting with me last week with some of your team and mine as well.

Dr. Clancy, I spoke to you by phone this week. I would just say to my colleagues, we have something in Delaware called the Delaware Health Information Network, which is just a great way to get better health care results for less money. It encourages collaboration and sharing by all kinds of providers all over a State, and but for Dr. Clancy's support in the early days, that might not exist. So we thank you for that.

Mr. Culpepper, I do not have anything good to say about you, but I am sure if I were to dig down, there is a lot I could say. I just do not know you. But we are glad that you are here.

I think a lot of times in terms of shared responsibilities and who is responsible for fixing a problem. In most cases, it is a shared responsibility. And in our own VA health care delivery system in Delaware, which I talked about earlier, where the mother ship is the hospital and the nursing homes just outside of Wilmington, a town called Elsmere, and we have two outpatient clinics in our two southern counties. But sometimes the veterans will tell us when things do not go well, and I am in and out of our veterans' facilities throughout the year. My staff is as well. And there is a lot we can learn from those visits, and we need to do that. So just by our demonstrating by our presence, it sends a message to the folks that are running the VA in our States that we care about this.

Families, family members, they contribute. Patients can tell us if things are not going well. They can tell our staff. I am going to be meeting with our Veterans of Foreign Wars (VFW) folks, representatives from Delaware, later this afternoon, and they are omnipresent, in and out of our hospital in Elsmere, Delaware. And they hear things that are going well and those that are not, and they can be very helpful in this.

We have also as a Congress the opportunity through funding to make sure that we are funding VA health care, writ large, that we are funding your operation, the Office of Special Counsel, that we are funding the IG's office. And you have a huge burden to carry, also to make sure that you heard us talking about the Senate. We still have too many folks that are serving as an IG in an acting capacity. God bless you for those who are willing to do that, but we ought to have Senate-confirmed IGs, and we are going to keep pressing this administration until we do.

We have a bunch of committees that have oversight over what is going on in the VA. We have a VA authorizing committee, Veterans Administration. We have an Appropriations Subcommittee whose focus is VA. This Committee is an oversight committee over the whole Federal Government. That is a whole lot to say grace over, so it is hard for us to cover every single piece of that. The Budget Committee has some jurisdiction over this. We are going to be going through in the next week or so a spending plan for our country, and the question is: Are we going to hold harmless the Department of Defense (DOD) budget and for the non-defense part of our Congress continue to expose many of those elements to sequestration? Is there some compromise there? Is there some way to do a deal?

So we have plenty of opportunity ourselves here to try to effect a better outcome in the health care delivery system. And we have a bunch of watchdog organizations that have sort of popped up and are good enough to share information with us and with others. And then there is the media. So there is a lot of shared responsibility, and we need to take that seriously.

Here is a short, easy question for each of you, and I will start with you, Mr. Culpepper, if you do not mind. But just give us one thing that you think could be done, should be done to ensure that whistleblowers—we will say just at the VA, whistleblowers at the VA—are better protected from retaliation? Either something we are already doing that we need to do more of, tell us what it is, or something we are not doing that we should be doing. Please, one thing.

Mr. CULPEPPER. Thank you, Senator. I think really education of our workforce, especially our managers. So recently our Office of General Counsel and our Office of Accountability Review has actually gone over and got some training from OSC that we are looking forward very much to rolling out in a much more robust fashion than just the online training system you heard from the last panel. Education is key. It is no excuse for managers that retaliate. It is not tolerated. It will not be tolerated. But we do need to make sure they are educated so it happens less frequently.

Senator CARPER. All right. Thank you. Dr. Clancy.

Dr. CLANCY. I would not disagree with that. I do think that we need better training for front-line managers, and that is a pretty high priority for us at the moment.

In addition to that, I think that we need to publicize and celebrate the good things that come out of people blowing the whistle. One of our former——

Senator CARPER. We did that. We did that, thanks to——

Dr. CLANCY. Yes.

Senator CARPER. That is what we did at the Dover Air Force Base.

Dr. CLANCY. And I have to say that Deputy Secretary Sloan Gibson this year, I believe, was the first time—I do not know if it was in history, but I think in many years; I have not been at the VA that long—actually attended the OSC Special Counsel's award ceremony for whistleblowers for VA, which I think is the right step.

But in addition to that, I think we actually need to make it really clear: This person blew the whistle, here is what we learned, and here is why veterans are better off. Because without that, I do not think we get the cultural change. Other than that, it feels so uncomfortable that the instinctive reaction is to withdraw.

Senator CARPER. All right. Thanks.

Ms. Halliday, just one example, please.

Ms. HALLIDAY. I think we need to spend our time on the education on the ranks of the people that are managing these whistleblower complainants. There is a lack of leadership. There are clearly problems with how they are addressing situations. Education there and an investment in how to properly lead is absolutely necessary.

Senator CARPER. All right. Thanks.

Ms. Lerner, please, same question.

Ms. LERNER. Everything they said, but since it has not been touched on and since it was the subject of my letter last week to the President and Congress, I think discipline is really key and has to be an area where we start shifting our focus. We have done a lot, we have seen a lot of progress, but the one area that I think remains to be really attacked is discipline. Senator Johnson said in his statement for this hearing the touchstone quality that makes any organization successful is accountability. And that is the missing piece, I think, right now.

Senator CARPER. [Presiding.] Senator Peters, you are next. Thanks.

OPENING STATEMENT OF SENATOR PETERS

Senator PETERS. Thank you, Senator Carper. And I would like to thank Chairman Johnson and Ranking Member Carper for holding this hearing, and I certainly appreciate the testimony from the witnesses. I think we all agree we heard some very disturbing testimony earlier this morning about the whistleblower process and the need to make some significant changes. Certainly as a country, we are all committed and have a solemn duty to take care of those who have taken care of us and who have kept us safe, and that duty certainly includes an obligation to take care of our Nation's veterans, and the 650,000 veterans that call my home State of Michigan their home.

But we also have a responsibility to support the VA employees who serve our Nation's veterans honorably and those who are willing to come forward to identify problems, despite the risk. Apparently from what we are hearing, there are significant risks within the VA to come forward to identify those problems.

So, with that in mind, Ms. Lerner, you stated in your testimony that complaints from VA employees make up between 35 and 37 percent of the complaints that your office gets governmentwide. I mean, those are striking numbers, one agency, 35 to 37 percent. So if you would tell this Committee—and I know you have mentioned some things, but elaborate—why you believe the VA accounts for such a large proportion of the complaints. And that certainly tells us an awful lot about the culture, but drill down a little bit for me and tell me why this is just an overwhelming number from the VA.

Ms. LERNER. Sure. And, I think that there are a lot of possible reasons for the increasing number of complaints. Let me just give you a few.

First, the VA is really big, and there are a lot of people who work there who are in health care facilities, so doctors, nurses, other health care workers who care really deeply about the mission of the VA, and because of the type of work that they are doing and because they are seeing people who are not getting the treatment that they need, they feel obligated to come forward. So it is an environment that is really ripe for disclosures.

Second, I think employees may be feeling now in the last year or two that they could really make a difference, and we know that the No. 1 reason that whistleblowers do not come forward is not fear of retaliation, but it is because they do not believe that it is worth the risk if it is not going to make a difference. Why expend

the time and energy and hope that goes into filing a complaint if you feel like it is going to fall on deaf ears?

So if there is a silver lining to the increase in complaints, it may be that people feel that they are going to be heard and they believe that their disclosures are going to be acted upon. And OSC is really getting results. So a third reason is they are more familiar with my agency, with the Office of Special Counsel, and they know that they will be protected from retaliation if they come to us. We have been doing a lot more outreach and training, and the number of whistleblowers who are getting relief at our agency is at an all-time high. We have over 100 corrective actions for VA employees compared to about 29 cases over the entire government just 5 years ago. So there has been an exponential growth in the work that we have been able to do to help whistleblowers.

So, in short, results matter. I think we are getting more of them. Whistleblowers know that they will make a difference when they come to us, and so I think it is a combination of those factors that is causing our increase in filings.

Senator PETERS. Thank you.

Ms. Halliday, in your prepared remarks, you also cited some similar capacity concerns that Ms. Lerner mentioned in her testimony as well. In fact, you said, "We receive far more allegations than we have the resource capacity to review, thus the OIG must be highly selective in the cases we accept." So could you elaborate for me how you prioritize those cases and exactly how quickly are they triaged? You obviously have to have some sort of management of those, and I would just like to get a sense of how that works.

Ms. HALLIDAY. Yes, I would. We get approximately 40,000 to 42,000 complaints on our hotline annually. We are probably one of the largest hotlines in the Federal Government, most active. We look at those complaints. They come in to an intake group who triages complaint, whether they belong to Criminal Investigations, have a flavor that a crime has been committed, or fraud; or they will go to Health Care Inspections if it is a health care quality of care issue. It would go over to the audit groups or contract groups, depending upon what the nature of the complaint.

At that point, the line offices take a very close look at whether the allegations are clear enough that we can do enough work to make a difference. In some cases, when a caller asks to be anonymous and they say, "It is happening in my health care facility," you might only know where the facility is. You do not know if it is in surgery or how to drill down in the allegation. So we try to find enough information that we can review the complaints. We take all allegations against Senior Executive Service (SES), which are VA senior executives and your GS–15 levels, and we take the majority of the allegations when they have a high risk of financial risk or risk to patient safety, and it is triaged from that point. We are looking at that bottom group right now to see is there a way to take more of these.

Senator PETERS. All right. Thank you.

Senator CARPER. Thank you, Senator. Senator McCaskill.

OPENING STATEMENT OF SENATOR MCCASKILL

Senator MCCASKILL. Thank you.

I have a piece of legislation that would require the firing of anyone found to be retaliating against whistleblowers. Have either the Office of Special Counsel or the IG's office found that there has been retaliation within the Department of Veterans Affairs against whistleblowers? Have you found incidents of retaliation?

Ms. LERNER. In our letter, we outlined a number of cases where employees who blew the whistle were subjected to disciplinary action, up to and including termination.

Senator MCCASKILL. And you determined that was, in fact, retaliation?

Ms. LERNER. I think it is fair to say yes.

Senator MCCASKILL. OK, and were those people fired, Dr. Clancy?

Dr. CLANCY. Many were disciplined. I do not——

Senator MCCASKILL. I did not ask that. Were they fired?

Dr. CLANCY. I think one person was fired?

Senator MCCASKILL. Out of how many?

Dr. CLANCY. I would have to get you the numbers.

Senator MCCASKILL. I need the numbers.

Dr. CLANCY. Sure.

Senator MCCASKILL. I need to know if there is a determination either by the IG or by the Office of Special Counsel that retaliation has occurred. I need to know how many instances that determination has been made and someone was disciplined as opposed to fired. Do you believe if this bill passes and it requires the firing of someone who retaliates, that it would have the impact that we are looking for here in this very troubling area?

Dr. CLANCY. So knowing how much work probably went into developing this legislation, I would actually like to read it before rendering an opinion. And I am always——

Senator MCCASKILL. It is simple. It just requires firing. What about the idea of requiring the firing of an employee who has been found to retaliate? Do you believe that idea—forget about the details of the legislation. It is pretty simple. Just assume it says just that. Do you believe that this is a good idea?

Dr. CLANCY. I believe in serious discipline. I worry a lot about more fear plummeted onto leaders who right now are feeling pretty fearful because what they feel like is if someone raises their hand or there is something that goes wrong at their facility, instead of saying, "This is great that you brought it to me, bring it on, we can solve these problems." They are worried that they are going to lose their job.

Senator MCCASKILL. But isn't that a culture issue, Doctor?

Dr. CLANCY. It is a culture issue.

Senator MCCASKILL. I mean, this is the problem.

Dr. CLANCY. Yes.

Senator MCCASKILL. They are more willing to hide the problem because they are worried about their bonus or they are worried about how it is going to look to people above them than they are the problem.

Dr. CLANCY. I agree with you completely.

Senator MCCASKILL. OK. That is why they have to be fired if they retaliate.

Dr. CLANCY. More firings I worry about. That was the reason I said reading the details would be helpful.

Senator MCCASKILL. OK. And I will look forward to your input after you read it, but I would like the numbers. How many people who have been found to retaliate were fired?

What if we had a clock, Deputy Inspector General Halliday? What if we had a clock that if the administration—this is putting you on the spot. Let me just put this on the record. I believe it is time to think about having a clock, and if the administration has not appointed an Inspector General after 6 months at an agency that has 35 percent of the whistleblower complaints in all of the Federal Government, then Ms. Halliday gets the job. She becomes the Inspector General because the administration has failed to act.

I do not know how else to do this. We went for months without an Inspector General at DOD, which really is a problem, a huge problem.

Finally, let me just ask this on budgets. Budgets matter. I assume that if you said in your opening testimony, Ms. Halliday, that you are one percent of the VA budget, and I know, Ms. Lerner, your caseload has increased dramatically. I believe your caseload has increased over the last 5 years by 58 percent. I guarantee you your budget has not increased by 58 percent. I know we are looking at long delays in terms of these investigations because my office deals with whistleblowers every day and many of them have waited over a year to have their complaints looked at.

Tell me what sequestration does to your budget, Ms. Lerner.

Ms. LERNER. So right now I have about 140 employees. We cover the entire Federal workforce, all civilian workforce more or less, over 2.1 million employees. During sequestration last time, we went down to 104 employees. I had to let 15 people go.

Now, I think if we tell Federal employees that they are going to be protected from retaliation if they come forward and make disclosures and that those disclosures are really important, we ought to be able to back that up. I personally feel really responsible for making sure that when people come to us, we are able to help them when they need help. It pains me when they have to wait and when we have to make triaging decisions about who are we going to help first.

Senator MCCASKILL. I think we should have a buzzer, and every time anybody in the Senate talks about that, it is OK to go to sequestered levels of funding for the budget. We should ring the buzzer and talk about what comes out of the other side of their mouth about expecting you not to have any delays when someone comes forward and files a complaint. You cannot have it both ways. You cannot expect the VA to do its work well. You cannot expect the IRS to have customer service. You cannot expect Inspectors General to do their jobs thoroughly. You certainly cannot expect whistleblowers to have their cases adjudicated fairly and in an efficient manner if we are cutting the money that provides the necessary personnel to do the work.

So I appreciate all of you very much, and I will look forward to getting the follow-up information from you. I have more questions

for the record, but since we are voting right now and the vote is just about over, I will say thank you for your testimony today, and in particular, thank you to the whistleblowers on the first panel that I was unable to question.

Senator CARPER. Senator McCaskill, thank you so much.

Senator Johnson is going to be back momentarily. He is voting, and I am going to recess the hearing for just a minute or two until he arrives.

I again want to thank you all for joining us today, and it is especially good to see you, Ms. Lerner and Dr. Clancy. Thank you for the difference you have made in the State of Delaware. Thank you so much.

Chairman JOHNSON. [Presiding]. Thank you, Senator Carper, for holding down the fort here.

I have just got a couple more questions, and I will give everybody an opportunity at the very end to make a closing comment.

Dr. Clancy, first of all, let me acknowledge, because this is true, I think the vast majority of people, doctors, nurses, administrators, from the lowest part of the organization all the way to the top, are definitely dedicated individuals doing everything they can to honor the promises made to the finest among us. I think that is just basically true, but we obviously have a systemic problem here, and the question I want to ask to you is: What is so difficult about holding the people that are retaliating, that are engaging in reprisals, what is so difficult about holding those people accountable? Because as you and I spoke yesterday in my office, there is nothing more corrosive to an organization than allowing bad apples to just get away with it and not being able to hold people accountable. So can you just kind of speak on why is it so easy, on the one hand, for the retaliators to retaliate and get away with it versus holding people accountable from the top of the agency down?

Dr. CLANCY. So I do not think it is that difficult. I think what is difficult is that it takes time to get all the facts together. It is rare that a story of retaliation is pure black and white. For example, people who are frustrated because they feel like they have been trying to make their voices heard and may not have been effectively doing so; people were not listening, their issues were blown off, may not always behave in a wonderful manner.

Supervisors do retain a responsibility to hold people accountable for the various functions of their job. We have heard some examples today which I think are horrifying. I agree with you on that. But there are other times when it is a little bit harder to sort out the actual facts.

So if there is a fair process, people should be held accountable, period. But I think the process needs to be fair, or people will be overwhelmed by fear.

Chairman JOHNSON. Again, having managed people for 30-some years, I understand the gray areas and sometimes the difficult nature of getting to the truth. But do you believe that we are holding people properly accountable?

Dr. CLANCY. No. And we are taking too long to do it, and we are committed to doing better on that front.

Chairman JOHNSON. Ms. Lerner, I would kind of like your assessment on that same question.

Ms. LERNER. Well, the reason that I wrote this letter to the President last week is because of these very concerns. We have learned that even in cases where the VA has substantiated wrongdoing by officials that implicates patient health and safety issues, the VA has done very little to impose discipline. Sometimes, they will do a slap on the wrist or a written reprimand. But very little is done to those who are responsible.

Chairman JOHNSON. But let me ask you, what is your assessment, your judgment of why that is? I know I am asking for an opinion here, but, why do you think that is?

Ms. LERNER. I am speculating. It is hard——

Chairman JOHNSON. I am asking you to speculate.

Ms. LERNER. But, the folks who are in positions of power and authority are higher up along the food chain, and the folks who are getting the punishment and the discipline tend to be lower on the food chain. And I think that, there may be more of a reluctance and resistance to go after folks who are more powerful in the organization.

I can tell you that headquarters VA, when I have had conversations with the Deputy Secretary and the General Counsel and the folks in Accountability and Review, the folks in D.C. really, I think, understand the importance of discipline and holding people accountable. They get it. The problem is it is down in the regions, and the regional counsel who have to enforce the disciplinary actions and bring them that are reluctant to do so. That is my sense, is that the problem is not at headquarters. It is really down at either the individual facilities or in the regions. And the regional counsel just are not willing to go after folks. But I do not have independent evidence of that.

Chairman JOHNSON. And, again, I have had enough contact with Dr. Clancy, who I think is a very good person. I think your heart is in the right place. But it does speak—it really is a top management problem. I mean, top management is going to have to enforce that middle layer where we are not holding people accountable. That is what is going to be required. And, again, from my standpoint, it is going to require an independent and transparent Office of Inspector General to provide that information to the public, to Congress, to put the pressure so that actually happens. Dr. Clancy.

Dr. CLANCY. Yes, the one point I was going to add is I think one of the challenges we have, not just in this arena but in almost every aspect of what we do, is enormous variability. It is a huge system. We meet veterans' needs wherever they happen to choose to reside in this country and a few other places. And I think the issue of discipline is not different from other areas.

So when then-Acting Secretary Sloan Gibson created the Office of Accountability and Review, a very, very big goal was to make sure that there was a far more consistent process. And I think that that is starting to work, but as I said, we need to pick up the pace.

Chairman JOHNSON. Let me ask another question, because I think this is just a real problem. When somebody would come to me kind of leaping over layers of management with a complaint, it is difficult to deal with because how do you go and take care of it without kind of tipping off the manager who just might engage in retaliation? And certainly what we heard in testimony is that in-

dividuals have come to the Inspector General's office and/or the Office of Special Counsel, frequently those complaints are heard and then they are turned right back over to the agency, thereby—maybe not revealing the name, but, people are smart and they certainly can make assumptions.

Ms. Lerner, I would like your assessment of to what extent that is a problem, and what can we do to correct that?

Ms. LERNER. When whistleblowers come to us, they have the option of remaining anonymous. It is not as effective sometimes because we really like when we refer a case for investigation for the IG or the Office of Medical Inspector to actually interview the whistleblower. So it is not ideal when they stay anonymous. But they can. They can remain anonymous.

Chairman JOHNSON. And then you do not go back to the agency or the department, correct?

Ms. LERNER. No; we still do. We still do, absolutely. And you are right, sometimes they can still be identified, but not always. When we send our letters, when we send our referrals to the agency for investigation, we have language in there that specifically says we expect you to take steps to make sure that no retaliation occurs. And the minute we get a phone call from one of our whistleblowers saying, "OK, they found out who I am, and I am being retaliated against," we then take action. We are on it. We do the best we can. And we can get stays of disciplinary action. We have been very active doing so, both informal stays and formal stays. Generally, if we contact the VA and let them know that someone is being retaliated against, they have been pretty good about holding off on taking disciplinary action. But it should not require the Office of Special Counsel to get involved.

Chairman JOHNSON. Ms. Halliday, why don't you speak to that potential problem?

Ms. HALLIDAY. I consider one of the major risks to the OIG and to the Department is our ability not to take all of the complaints that come in and process them. I think that there is a fear with whistleblowers and a perception that VA will not be fair in the process as complaints are reviewed and fear of potentially disclosure of their confidentiality. We are probably in the best position to review but it is a resource issue given the volume that has come in post-Phoenix on these complaints.

But I think that my executive staff clearly sees that as the major risk, and if we can work to get more controls over those more serious complaints that are coming into our office that absolutely need OIG's independent review, I think that it goes a long way to help the Department and it helps veterans.

Chairman JOHNSON. So I appreciate Senator Ayotte coming here, but I will beg her indulgence for one final question, because you raised the issue that I wanted to ask this question about, the overwhelming nature of the volume of complaints coming in. How overwhelming is it? Ms. Lerner, you gave us some sense of that. But I would like both of you to kind of speak to the volume coming in, how you are trying to deal with it, how you try to prioritize the complaints, and what are you going to do with these? We will start with you, Ms. Lerner.

Ms. LERNER. Sure. We are inundated and overwhelmed with complaints from the VA making up about 35 to 40 percent of our total caseload. As you said, we have gotten about 1,400 prohibited personnel practice complaints, most of which are retaliation; about 2,000 disclosures from the VA. So we are overwhelmed.

What we have done is set up our own sort of triage system. We have a senior counsel who is assigned to just the retaliation cases and working with the Office of Accountability Review at the VA to work on expedited settlements. We have worked with the VA to set up this expedited settlement process so that cases that have a lot of merit that we can identify quickly do not have to go through the full investigation process.

We have a VA team at the Office of Special Counsel that meets once a week and talks about the VA cases. I get updates every week on every new VA retaliation case that is filed. So we are doing everything we can to make these a priority.

That being said, we truly are overwhelmed and wish we could do a lot more.

Chairman JOHNSON. And, again, you are just dealing with the retaliation on whistleblowers. Ms. Halliday, then your office is dealing with all the whistleblower complaints.

Ms. LERNER. Well, we also deal with disclosures, too. So there are two tracks: one is disclosures of waste, fraud, wrongdoing, health and safety issues; and then also the retaliation cases.

Chairman JOHNSON. OK. Ms. Halliday, tell me about the caseload that you are dealing with here.

Ms. HALLIDAY. The caseload now is about 40,000 to 42,000 contacts a year. As I said earlier, the OIG VA's hotline, is one of the largest in the Federal Government, and the types of complaints that we get in are diverse. We have done exactly what OSC has done to perform better triage to make sure that we are gleaning out enough information at the complaint intake stage that we can understand the seriousness of the complaint so that we can process it effectively.

Chairman JOHNSON. So how many of 42,000, how many do you view as serious enough to actually take action on?

Ms. HALLIDAY. The number is very low, and that is why I have asked my hotline team to divide up for me exactly what is in the 40,000 contacts so I can take a look at it by risk. I would say the last numbers I thought I saw was 3,200 or so complaints were actually taken in the last fiscal year. So you can see the delta is huge.

Chairman JOHNSON. You have how many people adjudicating those complaints or looking into those?

Ms. HALLIDAY. Well, it is spread over three different directorates, depending upon if it is criminal, health care, or audit, and that would represent about 660 performing all OIG requirements.

Chairman JOHNSON. OK.

Senator Ayotte, I apologize, but you are up.

Senator AYOTTE. Thank you, Chairman.

I wanted to, first of all, associate myself with the comments that Senator McCaskill made earlier. It is just absurd that it has been 631 days that we have not had a permanent Inspector General at the VA, and I will join—I have written numerous times to the

President of the United States, but if the President really cares about getting this right, then he will nominate a permanent Inspector General. And I think it says a lot, unfortunately, that people on both sides of the aisle have asked him to do that, and we are 631 days into it, and I think our men and women in uniform deserve better than that so that you can have permanent leadership on this very important oversight issue.

And I agree with Senator McCaskill. If the IG positions are going to go vacant, then, I previously also sponsored the Vacant IG Act that she and Senator Boozman have introduced that would put Congress in a position to actually nominate these positions if the executive branch abdicates its responsibility.

I wanted to follow-up on the wait lists because, Dr. Clancy, the VA, of course, with what we went through last summer with the revelations of the wait list and the manipulated wait list and veterans literally who died waiting for care, and you talked about the fact that the VA is making progress. But as I understand it—there have been different estimates—only a handful of people have actually been fired as a result of what happened. And I regularly hear from veterans in New Hampshire who are really frustrated with the lack of action and accountability. And we heard that earlier with our panel of whistleblowers who felt that there was no accountability for the people who were not doing their jobs in serving veterans.

What is being done in terms of this accountability issue? Why hasn't there been more accountability over the wait list manipulations?

Dr. CLANCY. So, first, I want to emphasize that since this whole scandal broke out, we have taken the issue extremely seriously and have literally for over a year sat down with the Deputy Secretary every single day of the week to go over data, to look at which facilities are having the worst time, and often bringing them in by videoconference to find out what is the problem, what is the barrier, how can we help and so forth. No senior leaders got bonuses. No one can have in their performance plan performance metrics related to wait times and so forth. And what we found was that we provided a lot more care, both within VA through extended hours and so forth, and also buying it.

Senator AYOTTE. But just so we are clear for the record, because I have a separate bill on this clawback of the bonuses issue, there were many people who received bonuses who are in positions where, unfortunately, they were engaged in this issue. And, obviously, they received them, and so that is why Senator McCaskill and I actually have a bill to claw that back. But please go on.

Dr. CLANCY. Yes. Well, I was speaking for 2014 because Secretary McDonald came in 2014, so that had been already declared by his predecessor, and Secretary McDonald carried that through. And, very importantly, I think the shift was toward do not hide this information, tell us. Tell us how we can help. Do you need more space? Do you need more people? How is it that we at headquarters can actually help you address some of these barriers and so forth? So we have seen facilities all across the system step up to this challenge, but we have also seen increasing demand as we have gotten better at getting veterans in to be seen. Either in our

system, virtually by telehealth, or by buying care in the community, more and more veterans have come in. So we are still working this hard, and I have to say it is the No. 1 priority for our new Under Secretary, Dr. David Shulkin. So we are working that very, very hard.

As you know, or I think are likely to be aware, there was a huge array of investigations brought. Some are still ongoing. I would have to get back to you with numbers so that I am really confident about how many senior leaders are still under investigation for wait list issues. It has taken quite a bit of time.

Senator AYOTTE. Well, I would appreciate it, and I think that for all of us, there is great frustration in not hearing the accountability. And so it is great to look at data.

Dr. CLANCY. Yes.

Senator AYOTTE. But real people were involved, unfortunately——

Dr. CLANCY. Absolutely.

Senator AYOTTE [continuing]. In manipulating these wait lists, and when you think about the people not being held fully accountable at all levels of the VA for this atrocity, what it does is it sends a message through the organization, through these other cases we have heard about, that is one, to Ms. Lerner's point, of not accountability at each level. And if you are not held accountable for what happened with these wait lists, I mean, what will people be held accountable for I think is a question. So I think all of us want to see more accountability and more people being held accountable, and, by the way, the people who are doing a good job rewarded, and instead of being in a position where they bring misconduct to light, supported by saying let us work to solve the problem that you brought to light, as we heard from our earlier panel.

Dr. CLANCY. Yes, and I was not, I hope, contradicting that, and we will get you an up-to-date accounting of where all this stands. I was just acknowledging that thorough investigations take time, and really our first priority was to make sure that veterans got seen as soon as possible—in other words, to address the patient care issue and then get into the accountability. And, frankly, how do we get there? The Secretary through his efforts has really led a number of other important areas, really strongly encouraging, actually requiring facility leaders to get out and talk to the clerks on a regular basis.

Senator AYOTTE. So I know my time has expired, but Ms. Lerner testified that, as I understand it, if I am correct in this, 35 to 40 percent of the complaints you receive just pertain to the VA?

Ms. LERNER. That is correct.

Senator AYOTTE. And this is across the whole of government, correct?

Ms. LERNER. Yes.

Senator AYOTTE. Well, that is a huge number. So I guess what I also want to understand is what are we doing in terms of looking at the number of complaints systematically in terms of what issues they repeatedly raise and making sure that there is systematic change being driven by the huge volume that clearly speaks for itself as you look at the whole of government for Ms. Lerner to be receiving 35 to 40 percent from, one agency.

Dr. CLANCY. Well, I think Ms. Lerner—and if I misquote you, please speak up—did acknowledge that there might be a bit of a silver lining there, and I would actually agree with that, if people actually do feel free to contact her office. But, ultimately, there are a lot of other ways that people can make their voices heard.

Senator AYOTTE. So, systematically, what are you doing with this? Let us say you have whatever percentage of whistleblower issues, of retaliation, whatever percentage in terms of waiting for care. I am just coming up with different categories. What is the VA leadership and at all levels doing to incorporate the complaints? Obviously, individually they need to be investigated, but systematically, how is that feedback being addressed by the VA?

Dr. CLANCY. Systematically, certainly we address the feedback once the whole set of investigations has been completed, but in addition to that, we are not waiting for that. We are also looking at data all the time. And we have identified a tool and built a tool to let supervisors and front-line managers as well as their directors know if there are scheduling irregularities. This is not saying that you are wrong. What it is saying is we are seeing something in the data that looks really funky here; you need to go look at it. And we are encouraging a lot of engagement with front-line employees so that we can hear from them directly.

We also look at things as to whether people report issues of patient safety that do not actually go to the Office of Special Counsel. We have seen an increase in that this past year, which I actually think is a good thing if we are acting to follow-up on it and address those issues.

Senator AYOTTE. Well, Mr. Chairman, as you know, we could be on this topic for a long period, but this is something—I can think of no more important issue for this Committee to address in terms of more accountability, and obviously the issues we heard earlier with the panel on the whistleblowers as well and support for them within this organization. And so I look forward to working with you on this.

Chairman JOHNSON. Thanks, Senator Ayotte.

Again, I will give everybody an opportunity to make a closing comment. Before I do that, I do want to talk to Dr. Clancy. This is really a subject for another hearing, but I would be interested in Senator Ayotte confirming this as well. I am hearing repeatedly from veterans that their requests for the Veterans Choice Act are being denied. And, again, I just want to say I appreciate your willingness to take up a particular case. I cannot really reveal the individual's name. I am not sure we have the disclosure yet. But this is a Vietnam era veteran who early in August was diagnosed with Stage IV pancreatic cancer, really cannot travel the 120-plus miles to where the VA tells him he needs to get treated, and his request for treatment closer in a very high-quality private sector hospital in Green Bay is still being denied.

It is an issue I am hearing repeatedly. They are adjudicating every one of these issues, but I really do want to make sure that you are aware that it is a real complaint I am hearing, but I truly appreciate you being willing to take a look at this one particular case, because this gentleman's time is precious, and it really does

need taking a look at, so thank you very much for doing that. With that——

Dr. CLANCY. Let me just say very briefly, we have been buying more and more care in the community over the past 10 to 12 years, and what we have gotten to is a place where we have six or seven different pathways to do that, including the new Veterans Choice Act. We will by November 1 be bringing a plan to the Congress to say we are integrating them all into one, which I think is going to be a very big step toward our becoming a high-performing network where VA focuses on what we do really, really well and relies on community partners to actually help us with those other issues.

Chairman JOHNSON. And I do think that really should be the long-term direction. I realize this is not easy, but, again, I appreciate your efforts there.

We will start with you, Dr. Clancy, if you would like to make a closing comment.

Dr. CLANCY. Again, I want to express profound appreciation because we need to hear from employees all the time. I think of whistleblowers as one end of the spectrum, and if they feel like they need to exercise that option, then we should take that with the utmost seriousness. We are, but we need to pick up the pace.

But we also need to have many, many different outlets for employees and, frankly, we need to thank them when they speak up about those concerns and make that clear to others. We have started down this path. I am confident that we are going to get there, because I think Secretary McDonald and all of our leadership want nothing less.

Chairman JOHNSON. Thank you, Dr. Clancy. Ms. Halliday.

Ms. HALLIDAY. Yes, I definitely am trying to change the culture within the OIG to make sure that we reward whistleblowers when they come forward. I see the risks to them, to their career, as significant. I know as an IG we have to look at all the underlying facts, weigh the evidence, but it is so important for us to do that. I want veterans, I want VA employees to have trust in the OIG. I know they come to us for help, and they deserve nothing less.

Chairman JOHNSON. Well, I appreciate that.

I also want to make sure that you look at this Committee as an ally in that type of transparency, trying to accomplish your task and making sure that whistleblowers are not retaliated against. Again, I would ask you to work with us in our investigation, complying with the subpoena that has been issued that is not yet—again, we are all concerned about private health care information. We are willing to work with you. But we really do need to get this information.

Ms. HALLIDAY. We are working it. Your suggestion to work with Mr. Michael Horowitz at DOJ was a very good one. I have followed through, and we have gone through several of the obstacles. There are still a few remaining. And I have no problem working with Mr. Brewer and his team.

Chairman JOHNSON. To the extent of your good faith, I would say you still have a problem within the organization that continues to be a road block. That is just my honest assessment of it. Ms. Lerner.

Ms. LERNER. We have heard some terrible stories today, a lot of negative information, but I wanted to say I feel very optimistic that we are on the right path forward. The message from the VA leadership over the last year and a half has been very consistently positive and supportive of whistleblowers. The Secretary and Deputy Secretary are meeting with whistleblowers when they go out to facilities, and I think those are really positive signs, and it is going to trickle down, I hope, to the regions and the facilities. And identifying the problem is really the first step. They say light is the best disinfectant, and shining light on the problem is terrific. Working in partnership with this Committee, I am really confident that we can solve this problem, and I look forward to working with you in doing so and working with the VA and doing so.

Chairman JOHNSON. Well, thank you. One thing I always repeat—this is from my business background—is try and find the areas of agreement, and I think what you are seeing here is there is obviously enormous agreement that we have a problem here. There is also an enormous agreement that we do need to honor the promises to the finest among us.

So working with this Committee, working with the Office of Special Counsel, the Office of Inspector General, and the VA system, we need to address this problem. We need to come up with solutions. We need to act. And so, again, the commitment from this Committee is to work with you in good faith to find those solutions to honor those promises. Let us, again, concentrate on the areas of agreement that unite us rather than exploit the division. So that is certainly my commitment.

Again, I want to thank all of you, all the witnesses for their thoughtful testimony, their thoughtful answers to our questions.

The hearing record will remain open for 15 days until October 7th at 5 p.m. for the submission of statements and questions for the record.

This hearing is adjourned.

[Whereupon, at 12:44 p.m., the Committee was adjourned.]

APPENDIX

Opening Statement of Chairman Ron Johnson
"Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers"
Tuesday, September 22, 2015

As submitted for the record:

Good morning and welcome.

Today's hearing is our committee's second discussion of the hardships that federal employees face when they take the courageous step of coming forward to expose wrongdoing. This hearing will focus on whistleblowers from the Department of Veterans Affairs. VA employees who come forward play a unique role in the whistleblower community. Not only do VA whistleblowers expose waste, fraud and abuse in the federal government, they also expose wrongdoing that compromises the care of our nation's veterans. It is crucial that Congress and the VA embrace whistleblower protections to reduce misconduct and ensure that the finest among us receive the high-quality care they deserve.

As the events at the Tomah Veterans Affairs Medical Center in my state of Wisconsin have illustrated, when VA whistleblowers are punished for reporting wrongdoing, it can have drastic effects on veteran care. Three separate whistleblowers—Dr. Noelle Johnson, Ryan Honl and Dr. Chris Kirkpatrick, whose brother Sean is testifying today—brought their concerns to management about overmedication at the facility. In each instance, their concerns were ignored and they were punished for reporting the wrongdoing.

Whistleblower retaliation and abuse of authority by management at the Tomah VAMC created a culture of fear among the staff that compromised veteran care. Had the facility and the VA Office of Inspector General listened to these whistleblowers, Jason Simcakoski may have not been prescribed the lethal cocktail of 13 different medications that killed him last August.

Whistleblower retaliation within the VA is by no means isolated to Tomah. In fact, from accounts we will hear today, the VA has a cultural problem with whistleblower retaliation. The Office of Special Counsel is the independent investigator of whistleblower claims brought by federal employees and handles cases involving both the disclosure of wrongdoing as well as whistleblower retaliation. In 2014, the OSC received more retaliation complaints from VA employees than from Department of Defense employees, even though the DOD has twice as many civilian employees as the VA. For 2015, the OSC projects that it will investigate more than 1,400 retaliation complaints from VA employees alone. VA cases are estimated to make up 35 percent of the OSC's entire retaliation caseload. In June, Special Counsel Carolyn Lerner described the influx of complaints coming from the VA as "overwhelming."

The purpose of today's hearing is two-fold. First, we will hear the stories of four VA employees who raised concerns about wrongdoing that they witnessed in VA facilities across the country. The stories these individuals tell illustrate the wide variety of challenges and hardships that whistleblowers face when they come forward to report wrongdoing. In addition, the accounts from our whistleblowers will

show that when a VA whistleblower suffers retaliation, not only does it harm the whistleblower, it ultimately compromises veteran health care.

The second goal of today's hearing is to look for solutions that not only enhance whistleblower protections but also address the apparent cultural problem the VA has in regard to whistleblowers. Congress—especially this committee—and the VA have a shared responsibility to ensure that there will be zero tolerance for whistleblower retaliation. I look forward to working with the VA, the VA Office of Inspector General, and the OSC to craft solutions that foster a culture within the VA that encourages employees to report wrongdoing without fear of retaliation and reprisal.

As a founding member of the Senate Whistleblower Caucus, I have made it a priority to raise awareness about the need for adequate protections against whistleblower retaliation. I have created an email address, *whistleblower@ronjohnson.senate.gov*, to provide federal employees, including VA employees, a venue in which they can confidentially and safely report wrongdoing to Congress.

The touchstone quality that makes any organization successful is accountability. Moving forward, it is vital that we work to ensure that there will be zero tolerance for whistleblower retaliation within the VA and that all wrongdoers are held accountable for their actions. I thank the witnesses, especially the courageous whistleblowers, for testifying before the committee today, and I look forward to working with my colleagues in continuing our bipartisan efforts to enhance whistleblower protections.

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Statement of Ranking Member Thomas R. Carper
"Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers"
September 22, 2015

As prepared for delivery:

Thank you, Mr. Chairman, for calling this hearing today. It's been one of my top goals during my time in the Senate to find bipartisan ways to improve the efficiency and effectiveness of our federal government and get better results for less money. One of the key ways to do that is to root out waste, fraud, and abuse.

Whistleblowers can play a key role in these efforts. They're often the first to raise concerns and highlight instances where we can better serve the American people. Today, we'll hear from three whistleblowers and the family member of another. Their testimony tells a powerful story about management dysfunction at the Department of Veterans Affairs (VA).

I'm often reminding myself of my core values. 1.) Do what is right 2.) Focus on excellence in everything we do 3.) Never give up, and 4.) Treat others how we want to be treated – the Golden Rule. Without people who are willing to stand up and say something when they see something that is wrong, it would be much harder to root out waste and inefficiencies in federal programs. And in order to encourage people to stand up, we need to ensure that they will not be punished for doing so.

Our second panel will feature representatives from the VA, the VA Inspector General (VA OIG), and the U.S. Office of Special Counsel (OSC). I hope to talk with them about how they can better work within their own organizations and across government to ensure that whistleblowers are heard and protected after they speak up. Unfortunately, there is much work to do to better ensure that individuals feel free to come forward with problems they find without fear of retaliation.

I have been a long-time proponent of strengthening agency oversight by hearing from and protecting federal whistleblowers, as have a number of current and former members of this committee. I hope we can learn some valuable lessons today about the experiences some whistleblowers face. I'd also like to learn more about what we can do to better support them and improve the difficult situation they seem to face at the VA and elsewhere.

I've seen firsthand how hard it can be to be a whistleblower thanks to an experience that I had with a whistleblower a few years ago in Dover, Delaware. A whistleblower from the Dover Air Force Base contacted my office with information about mismanagement at the base mortuary. My office was able to help draw attention to both these issues and the retaliation the whistleblower was facing. In the end, the Office of Special Counsel investigation led to disciplinary action against several people in leadership

positions at the Base and to the reinstatement of this whistleblower and others there. I was struck by the courage of these brave whistleblowers who risked so much to right a wrong.

I know there are many more across the country and throughout the federal government who make the same brave decision to speak up every day. I take seriously the responsibility we have here in Congress to listen to them, protect them, and make sure we right the wrongs they bring to our attention.

I do, however, want to note a concern I have raised before in other hearings that some of the whistleblowers here today have retaliation claims that have not yet been substantiated, and cases that are still pending. I want to respect the independent, objective processes that Congress has set up at the Office of Special Counsel, the Merit Systems Protections Board, and elsewhere. I do have some concerns about publicly discussing cases that involve ongoing investigations and litigation.

That said, I'm glad that we have the opportunity to hear from the witnesses and appreciate them taking the time to testify before us today. I look forward to hearing from them and hope they can better inform both our work and the work of our witnesses on the second panel.

One issue that I want to raise in closing is Inspector General vacancies, and in particular the longstanding vacancy at the VA's Office of Inspector General. It is unacceptable that this important office has been without permanent leadership for close to two years. Earlier this year I joined with all of my colleagues on this Committee in sending a letter to the President urging him to fill all IG vacancies, and another specifically pointing out the importance of filling the VA IG vacancy.

Simply put: permanent leadership of the Department of Veterans Affairs Office of Inspector General is long overdue and would go a long way toward providing stable leadership and oversight of the agency. This hearing will serve as another reminder of the need to fill that vacancy.

Again, I look forward to the testimony and learning today how we can better protect whistleblowers.

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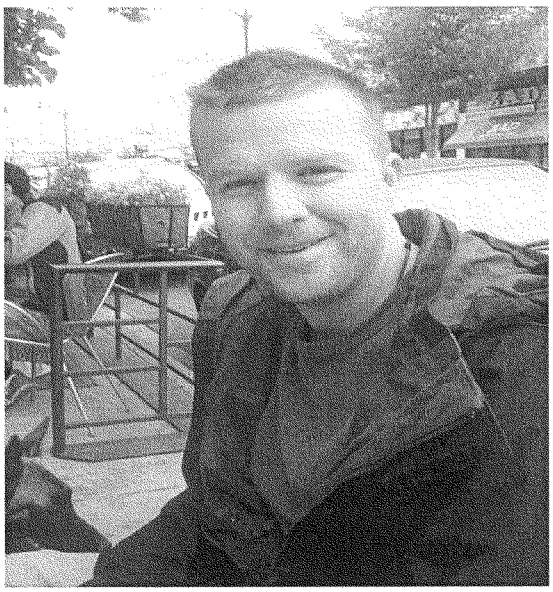
Testimony of Sean Kirkpatrick
September 22, 2015



On behalf of our parents and entire family, we would like to thank the U.S. Senate Committee on Homeland Security and Governmental Affairs for holding this hearing titled "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers."

It is our honor to speak today for our brother, Dr. Christopher Kirkpatrick, who was a psychologist and whistleblower at the Tomah VA Medical Center from September 14, 2008 – July 14, 2009. Chris was fired because he raised questions about the large amounts of narcotics ordered and given to the patients in the PTSD and Substance Abuse Programs. Later that same day, he committed suicide.

Through Chris's own words and written documentation provided by his Union Representative, Lin Ellinghuysen, are we now able to speak on his behalf today.

Chris relocated to Wisconsin in 2008 to accept a temporary position as a graduate psychologist at the Tomah VA Medical Center. He was required to obtain a minimum number of supervisory approved clinical hours, take the State Boards and become licensed within the first two years of his appointment. He was trained in treating Post Traumatic Stress Disorder (PTSD), substance abuse and chronic pain.

In an application for a psychology internship, Chris wrote: "Experiences have taught me to be grateful for being able to choose my own professional path. In reflecting on my life and finding myself closer to finally realizing my goal of becoming a clinical psychologist I am confident that I have chosen a path with heart, grateful that I have the ability to pursue a career that I find interesting and rewarding. I am interested in applying my energies in ways that will improve the

lives of people, research with utility that will inform social policy, especially the effects of trauma on the brain and behavior."

He wrote: "I would very much like to make a career out of serving the men and women who have served our country. All of my previous clinical, educational and research experiences provide me with a unique skill set to serve this population."

Chris was passionate about his chosen profession and especially interested in the use of innovative treatments for PTSD. During an internship, he began a program for veterans using Yoga Nidra and held weekly classes which the veterans used to support their sleep. He also offered training to the medical residents and staff. In addition, Chris was also trained in and incorporated Integrative Restoration (iRest), Eye Movement Desensitization and Reprocessing therapy (EMDR) and meditation.

While at the Tomah VA Medical Center, Chris told us that he was concerned about the overmedication of many of his veteran patients and raised questions – therapy sessions that he was facilitating were not effective, because the veterans were not alert, lethargic/too impaired and drugged due to the overmedication side effects so he could not help them.

On April 21, 2009, he telephoned the Union Office expressing concern that he could "be in trouble" with the Chief of Staff (Dr. David Houlihan). Two days later, April 23, 2009, in an email to his Union Representative he wrote that he was told of an accusation made by a Physician Assistant (PA) that he "…was inappropriate somehow in discussing medications that patients [who] we both see are prescribed…" He noted that he did have conversations with this PA "...about medications and possible side effect/adverse reactions they [veterans] were experiencing…these situations put me into an ethical dilemma." He continued: "Based on what others have told me, I have every reason to be very afraid of Dr. Houlihan [Chief of Staff]. I have sacrificed a lot to move up here and do the kind of work I excel at and help people in. I need help."

On April 30, 2009, Chris received a Written Counseling from his immediate supervisor based on information received from the Chief of Staff, noting that he "…criticized the PA for doing psychotherapy, as well as for what medications the PA was prescribing for the veterans in the program." Chris was told he "...should not be 'educating' patients about what medications they are on." He was "…advised to focus on his own work, and counseled that he should avoid advising on medications as it is not in his scope of practice."

May 4, 2009, in an email to his Union Representative, "I'm still really concerned about things but will keep my head down and hope for the best. Thanks again for your help and encouragement!"

May 13, 2009, Chris wrote to his immediate supervisor responding to the April 30th Written Counseling "…soon after our PA had joined the team, I and several other staff had asked

questions about medications after noticing changes in demeanor in our patients. I do not presume to prescribe medications but think it is important there be a dialogue between providers so as to best serve our patients. Patients have occasionally asked questions about their medications for which I refer them to their physician or other provider. Though neuropsychology and neuropharmacology are areas I am trained in and very basic information about how drugs work is covered in classes I teach at the Victor Center I only address the most basic of these questions and defer more detailed questions to the veteran's provider."

On July 14, 2009, ten months after he was hired, Chris was directed to report to the human resources office. While speaking with his Union Representative that morning before the meeting, when the subject of a worst case scenario (termination) was mentioned, he stated, "Oh no, I can't survive that." Chris's employment at the Tomah VA Medical Center was terminated during this meeting, attended by the human resources representative, his two supervisors and Union Representative, effective two weeks later, July 28, 2009. Chris was told his services were no longer needed "due to performance issues." The following allegations were made:

1) it was stated that he left the hospital without requesting all of his vacation leave, to which Chris responded "You told me you did not have a bank of comp-time, but that I could keep track of the extra hours I worked beyond my regular tour and then, off the record, take the informal comp-time by doing what I did. I used vacation for 2:00-4:00 pm and left at 1:00 pm and told [Program Director]." He was told by several others that "this is what we do here," which his Union Representative indicated was a breach of Dept of Labor regulatory laws since he was a bargaining unit employee and should be paid or given legitimate comp-time for any time worked beyond his 8 hour day;
2) it was stated that one time he inaccurately wrote down his leave, which had to be corrected by the Secretary;
3) it was stated that when he brought his dog to work (prior permission received, possibly a Saturday) and his dog went to the bathroom, someone other than Chris cleaned it up;
4) it was stated that he was on vacation and sick leave more on Mondays and Fridays - Chris responded that this was the first time he was hearing that there was a "pattern" with his leave and if he was sick on Monday, he would still make sure he was there for group therapy Tuesdays, Wednesday & Thursdays.

Chris replied, "I've been in a bad way. I have been taking a few days off for self-preservation. I told you that I should not be taking on so many complex cases that I needed help. I don't have the emotional resources to cope with this stress. I've been dreaming; I wake up 2:00-4:00am, anxious. I'm imagining about patients all weekend. After what the guy [patient] said he was going to do to me and my dog, I had to take a day of vacation on Friday [July 10]. A person needs processing of this work; it's great stress. Having to handle this without support or debriefing is too much; but I won't abandon the guys who are genuinely here to be helped." Chris was dedicated to his patients. He continued, "I know why this is happening ---it's because

of the note I put in [a veteran's] chart. He was difficult and violent. He didn't belong in this program. He stood at my [office] door and told me what he intended to do to harm me and my dog. I told you about this. The team decided this patient needed to be discharged and released from the program. On Thursday [July 9] he was still here. I charted this." Please note, Chris took a vacation day on Friday, July 10th and used a sick day on Monday July 13th because that threatening patient was not discharged and still there. Chris was terminated that Tuesday, July 14th. It was reported that there was no response from Management to Chris's plea for help.

Chris continued, "I told all of you prior that due to the challenging cases that I should not be working with [patient] anymore due to his threats towards me. I have had no one to talk with about what this patient stated. It bothers me greatly when I hear what some of the veterans tell me. I am isolated and don't have anyone to talk with." He was a recent graduate psychologist, studying for his license, with a full patient load, facilitating the group therapies on his own, hearing in great detail about horrific events experienced by his patients but yet he had no guidance and support, despite going through the proper chain of command for assistance more than once.

Chris told his Union Representative that after he charted on Thursday, July 9th about the threatening patient and the team decided to discharge the patient, but the patient was not discharged, he was told, by the Program Director, "I wish you had not put that note in the chart." It was noted by the Union Representative that both of Chris's supervisors praised his professional clinical skills because there were no issues, but they continued with the mundane accusations.

"I would never leave the veterans without having coverage. I regret writing the note about the patient. Despite threats...he should not be in the program. I am so committed to this. I give 110%. Please – I have no one to talk with..."

When it was mentioned that he had been arriving late for groups, Chris replied: "Yes, that was an issue at that time where I would be coming to a point in psychotherapy where a traumatized patient was opening up and I couldn't break off the session until after processing…I have improved and within the past month I have not been late one time."

Chris stated towards the end of the meeting, "You are killing me! You are telling me I am getting fired for [nonsense] reasons when I know it's about what I charted last Thursday in the patient's chart." It is our understanding that clinical staff are instructed to document information about threatening behaviors for care planning and to forewarn other staff as a legal requirement and ethical professional practice.

Chris continued, "I gave up everything to come here. My girlfriend, my family, everything. This will devastate me." He was asked by human resources representative: "…what you meant when you said 'you are killing me?'" Chris replied: "Just a figure of speech."

Chris's Union Representative tried to get him two more months as a temporary employee but management would not comply. Chris knew it would be difficult to find new employment in his field after losing this job and without his license.

In Chris's office, as he was preparing to leave, he stated: "You just wouldn't believe some of the things I hear…it's awful…but, of course, I can't repeat it. Sometimes it really bothers me what I hear from the vets and what they have done; and, I can't tell anyone. I carry it with me – I wake up at 2am and I can't sleep. I can't even begin to tell you what the guy said he was going to do to me and my dog."

It was later that afternoon that my sister and I each received a call from the local sheriff's office to tell us that Chris was dead from a self-inflicted gunshot wound. We had to tell our father that Chris was gone and were there as he told our mother.

The Tomah VA Medical Center did not disclose the circumstances of Chris' termination as related in this testimony. We were told that he had "missed too many days."

His Union Representative has explained that since Chris was a temporary employee, he did not have a right to independent third party review of his termination or statutory appeal rights requiring management to show just cause for his removal. "Employees with temporary appointments and recent hires still on probationary status have very limited protections against retaliatory terminations, suspensions and other unwarranted personnel actions."

It was not until we were contacted by whistleblower Ryan Honl last winter who put us in contact with Chris's Union Representative, Lin Ellinghuysen, did our family hear the actual circumstances of Chris's experience at the Tomah VA Medical Center as relayed in this testimony.

One thing that we want to make clear: the police report that was mailed to us in September 2009 contained 16 pages, page 17 and on, in the police report, documents a visit made to the sheriff's office late July 2009 by a Tomah VA Medical Center employee to report "known threats" against Chris along with documentation and detailed notes and emails provided by Lin Ellinghuysen, which has been summarized in this testimony. Since Chris's voice can be heard in these papers, we find it ironic then that the VA OIG white paper used this same report to try to discredit him.

The VA OIG white paper report released in June 2015 "strongly" recommended a "thorough review" of the police report filed for our brother's death, stating that the "evidence" indicates Chris was a drug dealer. This accusation was beyond offensive and disturbing for our family. How dare they! The haphazard attempt to discredit and slander Chris was absolutely outrageous to us when our brother was merely questioning opioid abuse and concerns that the veterans were not being cared for properly. He is not here to defend himself, so we will. We want Chris's good name and reputation cleared.

There was no investigation of his death. Our family would like to know why.

Our brother felt helpless and hopeless with the obstacles he encountered at the Tomah VA Medical Center. He wanted to improve the quality of care for our nation's veterans through holistic options and continuously questioned the overmedication practices which hindered his ability to treat his patients. He felt his personal safety disregarded when his life was threatened by a patient who was never dismissed from the medical center. Even after expressing concerns with his complex case load, it appears that no assistance was given, his concerns were disregarded. He had finally reached his goal of becoming a clinical psychologist, studying to obtain his license, then was fired as retaliation for speaking up for what was ethical and right. But... he was only a temporary employee...he had no rights....

Please listen carefully to our brother's final words to his Union Representative, before he got into his car and drove out of the parking lot at the Tomah VA Medical Center for the last time:

"Try to get a support system so that no one else has to go through what I did! Will you please do that?"

-Sean Kirkpatrick
-Katy Kirkpatrick

In Dr. Christopher Kirkpatrick's memory and in support of all VA employees who work in highly stressful positions providing medical and mental health care to Veterans, we offer the following recommendations for change:

1. We urge Congress to mandate the development of a comprehensive support system for VA medical and mental health care professionals, that provide needed consultation services with trained professionals as part of their employment, and not to be seen as private treatment. These support services and consultations must maintain strict confidentiality. Currently, all that is offered at the Tomah VA are one or two sessions with a VA provided counselor; after that, employees are left to manage these very intense job duties on their own without time to debrief,

refresh or regroup. Particularly, psychotherapy with Veterans is difficult and draining; and, can take a great deal out of a clinician emotionally and physically.

2. If not licensed when hired, (graduate) Psychologists are required to be licensed within two (2) years. They are not given time to prepare for the exam. Mentors could ensure there is appropriate patient care assignments –and- time set-aside for study. NOTE: Prep for exam requires 20hours/week of study time for 3-6 months.

As a graduate Psychologist, Chris was expected to counsel Veterans with complex needs, facilitate group therapy; participate in Care Planning Team Meetings --- along with all of the required reporting and documentation.

3. Develop VHA protocols for investigation of suicides of employees and recently terminated employees. The Tomah VA management and Police did not investigate Chris's death.

4. Develop VHA protocols for addressing threats patients make against staff.

5. We also request that lawmakers investigate the pervasive use of extended temporary appointments within the VA health care workforce, and the abusive use of terminations and other personnel actions against temporary and probationary employees, and mandate additional protections, both statutory and administrative for these most vulnerable employees who pay the heaviest price when they question the current way of doing things.

6. We urge Congress to take steps to ensure greater accountability for VA front line managers, mid-level managers and upper management who engage in retaliation against Whistleblowers and other front line employees who speak up for Veterans' needs.

7. Additionally, we urge Congress to review the current reporting structure for the Chief of Police at VA Medical Centers. Currently, they report to the Medical Center Director, rather than a separate entity that can address mismanagement or staff concerns without interference, such as the alleged illegal drug activity at Tomah.

8. We are thankful the Senators and Congressmen are addressing and putting into place checks and balances that will ensure the safe ordering of opioids as well as the development of guidelines for the safe combining of opioids with other addictive drugs in an earnest effort to keep Veterans safe.

9. Lastly but immensely important to our family, is our request that Chris's Official Personnel File and all information be sent to Sean Kirkpatrick. It is also requested that any and all Tomah VA Supervisory Notes, Reports of Contacts, etc., related to Christopher Kirkpatrick be sent to Sean Kirkpatrick.

Whistleblower 101 Oral Testimony

Brandon W. Coleman Sr.

Addiction Therapist

Ph.D. (c) MA, LISAC

Phoenix Veterans Affairs Health Care System

Oral Testimony Prepared for members of the United States Senate

September 22, 2015

Introduction

VA Whistleblowers risk the total destruction of their professional reputation for simply telling the truth. During my time at the Phoenix VA I have lost 6 veterans to suicide. Each one is like a punch in the gut. I have walked suicidal veterans to the Phoenix VA ER after hours only to have them not watched and they simply walked away unaccounted for. In October 2014 Phoenix VA social worker Penny Miller admitted to improperly accessing my own HIPAA protected Veteran Medical Records. This was only the start of improper and unlawful behavior that would persist over the following year.

Timeline of Events

December 6, 2014

I came forward to the OSC regarding the unsafe treatment provided to our suicidal veterans, along with my records being improperly accessed.

January 12 & 13, 2015

On January 12 and 13 ABC 15 ran stories regarding my OSC complaints. On the 13th hospital director Glen Grippen held a meeting with leadership of the Phoenix VA and VA legal counsel Shelly Cutts. Grippen proposed to terminate me for being on TV. Cutts advised Grippen that it would be illegal to remove me because of the Whistleblower Protection Act. But then Cutts stated, "Brandon could possibly be removed for unrelated misconduct." The problem with her statement is I had an exceptional employment record to this point.

January 20, 2015

On the 20th I attended a meeting with my section chief psychiatrist. The chief questioned my current "mental health". I said it's highly suspicious he was concerned now with my mental

health especially after Penny Miller had been in my medical records. Later that day I had a social worker accuse me of threatening him. It was simply not true.

January 21, 2015

On the 21st director Grippen requested I meet with him to share my OSC concerns. The director made an eerie comment. He stated, "Brandon, I just want you to know you are not being terminated YET." He actually used the word "yet." Director Grippen later admitted to saying this in his EEOC testimony.

January 23, 2015

On the 23rd social work chief David Jacobson held a meeting for 15-20 employees. An employee made an audio recording. An ER social worker stated "5 suicidal vets had simply walked out of the hospital during the past week," and Jacobson responded "we have been really lucky that nothing bad has happened. It was sheer luck." This proved that suicidal vets were really walking out of the hospital.

February 2, 2015

On February 2 I was placed on admin leave for allegedly threatening other employees. The letter stated I could receive care as a vet but I had to check in and out with the VA police. I immediately called the OSC to begin a retaliation investigation.

February 3, 2015

On the 3rd Grippen shutdown my highly successful 52 week Motivation for Change treatment program. 71 high risk vets no longer had long-term substance use disorder treatment.

February 4, 2015

On the 4th whistleblower Jared Kinnaman came forward to the OSC stating suicidal veterans were being mishandled.

February 26, 2015

On the 26th I attended a fact finding regarding my placement on admin leave. I was personally escorted by VA police Lt. Robert Mueller. Lt. Mueller ordered me to walk in front of him through the main hospital like I was a criminal. I was told by the fact finders after the meeting I would be cleared of any wrongdoing.

March 6, 2015

On March 6 whistleblower Lisa Tadano came forward to the OSC claiming suicidal veterans were watched by janitors and volunteers. She also learned employee Penny Miller had also accessed her treatment records without reason.

March 12, 2015

On the 12th I met with Secretary McDonald before President Obama came to Phoenix. I said it is highly questionable that I can have a one on one meeting with the most powerful man in the VA, yet if I go to the Phoenix VA for medical care I have to check in and out with VA police. He said he would look into it.

March 16, 2015

On the 16th the VBA said my service connected injuries had improved proposing to reduce my disability benefits by $300 per month. I have had 9 surgeries on my foot and walk with a cane. The timing was highly suspect.

March 19, 2015

On the 19th I received a letter from Grippen stating that I was no longer required to have a police escort. To date I have never received a letter clearing me of wrongdoing.

April 9, 2015

On April 9th I had a 2nd sensitive patient access report pulled and learned 2 additional coworkers had improperly entered my medical records.

April 14, 2015

On the 14th I was walking through the VA hospital on my way to a 12 step meeting with friend and former Navy Seal Carl Higbee. We were confronted by Grippen. I told Grippen what I was doing and went on my way to attend the meeting open to the public.

April 20, 2015

On the 20th I received a "gag order" from Grippen now forbidding from speaking to any other Phoenix VA employees but saying I could get medical care as a vet. How does a veteran get medical care without being allowed to speak to any employees?

April 24, 2015

By the 24th over a dozen media outlets contacted the hospital forcing Grippen to amend the letter acknowledging my right to free speech.

August 12, 2015

On August 12 I pulled a third SPAR report and learned another administrative officer Troy Briggs has accessed my records. I have not received care since January 2015 yet this employee was in my records on April 20, the same day director Grippen placed a gag order on me. Mr. Briggs is even CC'd to the gag order letter. Why would he be in my record this same date?

In Closing

It is a privilege to work for the VA, not a right. All employees including directors must be held accountable. Today I am calling on the committee to ask for a DOJ Investigation into the improper accessing of my HIPAA-protected veteran treatment records as retaliatory acts and as a

criminal act. I am also asking the committee to call for an investigation into Grippen's retaliation against me, including placing me on admin leave on baseless grounds, and for his attempting to manufacture grounds for my removal from employment His actions violated federal whistleblower law.

I find it sad that the only time congress is able to get an honest answer from the VA is when whistleblowers are asked to testify. There is something deeply disturbing about this fact. Thank you for the allotted time today.

Statement of Joseph Colon
Committee on Homeland Security and Governmental Affairs
September 22, 2015

Good Morning Members of Congress. My name is Joseph Colon. I am a Credentialing Program Support at the VA Caribbean Healthcare System in San Juan, Puerto Rico. I filed for whistleblower protection in August 2014 and my case settled on July 2015. Despite the above, retaliation against me and others similarly situated continues at that facility.

Before I provide my account of the events that have taken place with me, I would like to thank Senator Ron Johnson, Ranking Member Thomas Carper and the committee for their leadership and for allowing me the opportunity be part of this hearing "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers." and to explain what happens to a Whistleblower that comes forward.

The Whistleblowers in Puerto Rico really need the help from this committee to ensure that Whistleblower Retaliation does not keep on happening at our facility and that the supervisors are held accountable. Unfortunately, our Resident Commissioner Pedro Pierluisi does not even issue one statement against Whistleblower retaliation that occurs very often at this facility. Without proper oversight from our representative in Congress it makes it even more difficult for us whistleblowers in Puerto Rico.

Issues reported to the House Committee on Veterans Affairs, Office of Special Counsel, Office of the Inspector General and the Senate Committee on Homeland Security and Governmental Affairs:

- Dr. Carlos Rosado who killed a Veteran while doing an authorized procedure that his spouse needed for her residency program.
- Mr. DeWayne Hamlin arrest for Drunk Driving and having a controlled substance without a prescription.
- Director absences.
- Veterans Mental Health issues.
- Chief of Staff salary concerns.
- Anesthesiologist that gave an improper dosage to a Veteran. Ordered the Veterans medical record be documented with incorrect information.
- Physicians practicing with expired Medical licenses and without clinical privileges.
- Legionella found in the Physical Therapy Pool.
- Community Living Center Director, who was the direct supervisor of the area that was not helping elderly Veterans with bathing, using the bathroom, feeding and drinking was promoted to Associate Chief of Staff of Geriatrics and Extended Care
- Registered Sexual Offender that provides disciplinary recommendations to management.
- Unfair hiring practices, and limiting opportunities for Veterans from outside the facility to apply for jobs.
- My immediate supervisor's fraud with the travel voucher program.

- Mr. Jaime Marrero being selected as Associate Director of the hospital, even though when he was the boss of Facility Management Service, there was an oxygen incident that caused Veterans to die.

The retaliation that I experienced from top levels of management at the VA Caribbean Healthcare System before the Office of Special Counsel settled my retaliation claim at the

- Investigated four different times for the same allegations.
- I was illegally placed on a permanent work detail on two different occasions; once to the Facility Management Service which is located in the basement of the hospital and the other to a confined dark room as a Switchboard Operator for Police Service.
- Issued a proposed removal on two different occasions.
- Received a three day suspension.
- No performance appraisal issued to me for the twenty months when I was on detail.
- Non-Selections when I applied for other positions in the hospital.

The retaliation and harassment that I have experienced after the Office of Special Counsel settled my retaliation claim at the VA Caribbean Healthcare System and returned me to my Credentialing Program Support position:

- Moved the Credentialing and Privileging Department from the Fifth floor of Executive Suite to an office area with no windows on the third floor. The new office is located next to Human Resources and to Mr. Tito Santiago's office, the same areas where I reported numerous concerns and that this medical facility has a registered sexual offender recommending disciplinary actions against employees.
- The afternoon prior to me returning to my position, the Human Resources Manager Mr. Omar Ahmed issued an e-mail warning his personal that share the same lounge with me, to not discuss any Human Resources business in the lounge area.
- No electronic e-mail access for over two weeks.
- No work assignments for three weeks.
- Expired my high blood pressure refill medication without notifying me.
- Not selected for the Clinical Administrative Specialist position, even though I was the most experienced member of the Department. The two panel members that interviewed me, are the same members that I reported wrongdoing about. In addition, the Chairperson for the interview, was interviewed during my fact finding investigation.

Unfortunately at the VA Caribbean Healthcare facility in San Juan, Puerto Rico this is NOT the only incident of retaliation, that has occurred under Mr. DeWayne Hamlin's, Miss Nayda Ramirez, and Dr. Antonio Sanchez leadership. These three individuals are directly responsible for all cases mentioned in my statement.

- Miss Rosayma Lopez, Freedom of Information and Privacy Officer, a mother of three small children was issued a Proposed Removal because she failed to find anything against me and for answering properly the Freedom of Information requests that I had submitted. She was removed from her position as Privacy Officer and placed on detail to

the Logistics Department. But due to the constant harassment of Miss Nayda Ramirez and Mr. Jose Pagan she had to take sick leave for over two months. Upon her return she was placed under the Education Department and right now she is currently home on administrative leave as the Office of Special Counsel resolves her case.

- Dr. Ivan Torres reported to the Chief of Staff that Miss Miriam Marti, who is Compensation and Pension Clinical Supervisor was not complying with her tour of duty and that Compensation & Pension physicians were not complying with their Compressed Time work schedule, it requires them to work ten hours and they were only working five hours. After he disclosed this information to the Chief of Staff he was removed from his position as Chief Operating Officer for the Executive Team. His office was relocated from the Executive Suite to another office with no windows. His case is also pending Office of Special Counsel resolution.

Management here in San Juan, Puerto Rico actually reward people that actually help them build a case to fire a Whistleblower.

- Miss Maritere Acevedo, who conducted the fact finding against me was rewarded as the Quality Management Director, even though she stated in my fact finding "In terms of Mr. Colon going over the Chain of Command and gathering information, this is seen as a pattern that does have an impact on the efficiency and effectiveness of his unit". She also believes that there is a potential ethical issue for becoming a witness in a discriminatory case.

- Mr. Victor Sanchez was rewarded with a promotion as Medical Administrative Supervisor in Mayaguez even though he sanitized and deleted a portion of the document that was used against me and he could not provide the original document when the investigator asked for it. Also the report states that he might have violated privacy and he should have been investigated but never was.

As you can see in Puerto Rico, that both these people were rewarded with better positions but Miss Rosayma Lopez was issued a termination letter. The difference is because Miss Rosayma Lopez was ethical and failed to do what management wanted to her to do. There is no better example, to show management's unethical behavior and what levels they will go to fire the Whistleblower. The Secretary of the Veterans Affairs must do the correct thing and place Mr. DeWayne Hamlin, Miss Nayda Ramirez, and Dr. Antonio Sanchez on detail until an accurate investigation is completed regarding their conduct and their behavior towards those who dare to bring into the light abuse and mismanagement.

If the Secretary of the Veterans Affairs fails to do so, he actually is accepting that a WHOLE Executive Team can participate in retaliation and he actually supports it. How many Veterans are being hurt because employees live in fear of retaliation? How can you run a successful organization without accountability?

It's easy to retaliate against someone when that supervisor does not have to pay for attorney's fees, is not held accountable and the American taxpayers foot the bill when compensatory damages are being paid.

I truly believe that since the Secretary of Veterans Affairs has failed to impose discipline to his employees, Congress should give that authority to the Office of Special Counsel to discipline employees who are found to have retaliated against a Whistleblower. It's time to really protect future Whistleblowers and implement a zero tolerance policy in regards to Whistleblower Retaliation.

Thank you again for this opportunity. I welcome your questions on the issues I've noted or any items I've submitted to the committee.

Mr. Christopher Shea Wilkes
VA Truth Tellers
United States of America
3646 Youree Drive
Shreveport, Louisiana 71105
September 18, 2015

The Honorable Senator Ron Johnson
Chairman of U.S. Senate Committee on
Homeland Security & Governmental Affairs
340 Dirksen 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

Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate
Committee on Homeland Security and Governmental Affairs

"Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers"

September 22, 2015, 9:30 A.M.

Chairman Johnson, Ranking Member Carper, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our work with whistleblowers at the Department of Veterans Affairs (VA). Since April 2014, our office has seen a sharp increase in the number of whistleblower cases from VA employees. These cases fall into two categories: retaliation complaints and disclosures of wrongdoing.

In response to retaliation complaints, and working in cooperation with the VA, we have secured relief for dozens of whistleblowers, helping courageous employees restore successful careers at the VA. The number of victories for whistleblowers is increasing steadily. In 2015, we will more than double the total number of favorable outcomes for whistleblowers achieved in 2014. OSC recently settled a retaliation complaint filed by Joseph Colon, who testified on the first panel. We are actively reviewing the retaliation complaints and whistleblower disclosures filed by Brandon Coleman and Shea Wilkes, who also testified today.

In disclosure cases, OSC's work with whistleblowers improves the quality of care for veterans. Whistleblower disclosures also can play a pivotal role in promoting accountability. The VA has disciplined or proposed to discipline 40 employees as a result of wrongdoing whistleblowers identified in disclosures to OSC. This is substantial progress. However, as detailed below, our review of disciplinary actions in response to recent whistleblower disclosures indicates that discipline is being inconsistently imposed.

This statement describes our process for investigating retaliation complaints and reviewing whistleblower disclosures. It provides updated statistical information on case numbers and outcomes, and it summarizes recent cases in which OSC secured relief for whistleblowers. Finally, it highlights ongoing challenges and issues the Committee may want to consider to strengthen OSC's ability to investigate whistleblower retaliation complaints.

OSC Investigations of Whistleblower Retaliation Complaints

A. Process

OSC investigates allegations of whistleblower retaliation, one of the thirteen "prohibited personnel practices" that federal employees may challenge with our office. After receiving a retaliation complaint, we conduct an investigation to determine whether the employee has been fired, demoted, suspended, or subjected to another personnel action for blowing the whistle. If

OSC can demonstrate that a personnel action was retaliatory, we work with the agency to provide relief to the employee. This can include reinstatement, back pay, and other remedies, including monetary damages. OSC also commonly works with the agency involved to implement systemic corrective actions, such as management training on whistleblower protections. Frequently, we resolve cases through alternative dispute resolution, including mediation. If the agency does not agree to provide the requested relief to the employee, either through mediation or based on our investigative findings, we have the authority to initiate formal litigation on behalf of the whistleblower before the Merit Systems Protection Board (MSPB). In egregious cases, we can also petition the MSPB for disciplinary action against a subject official.

B. VA Retaliation Complaints, by the Numbers

Government-wide, OSC is on track to receive over 4,000 prohibited personnel practice complaints in 2015. Over 1,400 of these complaints, or approximately 35 percent, will be filed by VA employees. In 2014, for the first time, the VA surpassed the Department of Defense in the total number of cases filed with OSC, even though the Defense Department has twice the number of civilian employees as the VA.

We have taken a number of steps to respond to this tremendous surge in VA complaints. We reallocated a significant percentage of our program staff to work on VA cases. I assigned our deputy special counsel to supervise investigations of VA cases, and we hired an experienced senior counsel to further coordinate our investigations of VA cases. We prioritized the intake and initial review of all VA health and safety related whistleblower complaints and streamlined procedures to handle these cases. And, we established a weekly coordinating meeting on VA complaints with senior staff and case attorneys.

Working with the VA's Office of General Counsel (OGC), we implemented an expedited review process for whistleblower retaliation cases. This process allows OSC to present strong cases to the VA at an early stage in the investigative process, saving significant time and resources. To date, we have obtained approximately thirty corrective actions for VA whistleblowers through this process.

In July, OSC announced the resolution of Mr. Colon's case, as well as the retaliation complaint filed by Ryan Honl of the Tomah, Wisconsin VAMC, which I know has been of great interest to the Chairman, Senator Baldwin, other members of this Committee, and Mr. Kirkpatrick's family. These cases are summarized here:

> **Ryan Honl** – Mr. Honl was a secretary in the mental health unit at the Tomah VA Medical Center in Tomah, Wisconsin. In addition to other concerns, he disclosed the alleged excessive prescription of opiates to patients. On the same day he made a disclosure to the VA Office of Inspector General, the VA stripped Mr. Honl of his job duties, locked him out of his office, and isolated him from co-workers. Shortly thereafter, he resigned. The VA and Mr. Honl settled his complaint through the expedited process with Mr. Honl receiving several corrective actions, including the removal of negative information from his personnel file and monetary damages.

Joseph Colon Christensen – Mr. Colon is a credentialing support specialist with the VA Caribbean Health System in San Juan, Puerto Rico. Mr. Colon reported concerns relating to patient care at his facility and information about alleged improper conduct by the director of his facility. In September 2014, two days after a newspaper called the facility's director asking for comment on a story about the director's conduct, the facility's chief of staff issued Mr. Colon a notice of proposed removal. In late December, the VA replaced the proposed removal with a three-day suspension and detailed him to a different position. Prior to his disclosures, Mr. Colon had an unblemished disciplinary history and had received "outstanding" performance reviews. The VA and Mr. Colon settled his retaliation complaint through the expedited process with Mr. Colon receiving several corrective actions, including the repeal of his suspension, a return to his position, and compensatory damages.

These are important victories for employees who risked their professional lives to improve VA operations and the quality of care provided to veterans. Additionally, in the last two weeks, in cooperation with the VA, OSC resolved two additional significant retaliation claims, summarized below:

Philo Calhoun – Dr. Calhoun was a surgeon at the VA Roseburg Health Care System in Oregon. He raised numerous patient care issues with senior VA officials, the press, and Congress, both while he served as chief of surgery and after he stepped down from that post in 2013. In August of 2014, Dr. Calhoun reported that the new chief of surgery was performing colonoscopies incorrectly. A subsequent review by the chief of gastroenterology concluded that, out of the 80 colonoscopies reviewed, the new chief performed more than 90 percent incorrectly. After Dr. Calhoun reported these results to VA officials, the chief of surgery retaliated against him by taking away his surgical duties, giving him a lowered performance evaluation, and blocking his reassignment to another facility where he could maintain his surgical skills. OSC settled Dr. Calhoun's case through the expedited process. At Dr. Calhoun's request, the VA reassigned him to the Portland, Oregon VA Health Care System and reissued his 2014 Proficiency Report with an "outstanding" rating, consistent with his previous evaluations.

Bradie Frink – Mr. Frink is a disabled Army veteran who was hired at the Baltimore Regional Office (BRO) of the Veterans Benefits Administration in February 2013. VA policy required the BRO to transfer Mr. Frink's benefits claims folder to another VA facility for processing. However, the VA lost Mr. Frink's claims folder. Despite several requests to the VA to locate his claims folder, it remained lost. Mr. Frink sent a request for assistance to Senator Barbara Mikulski. The Senator's office contacted the BRO about Mr. Frink's claim. Shortly thereafter, the VA terminated Mr. Frink during his probationary period. OSC settled the complaint through the expedited process. The VA provided full corrective action for Mr. Frink, including reemployment with the VA, back pay for the months of unemployment, and compensatory damages for emotional distress. OSC further recommended that the VA consider disciplinary action against two of Mr. Frink's supervisors.

In addition to cases resolved through the expedited relief program, we are steadily increasing the number of corrective actions in all VA cases. In 2014 and 2015 to date, OSC has secured either full or partial relief 116 times for VA employees who filed whistleblower retaliation complaints, including 84 in fiscal year 2015 alone. These positive outcomes are generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution, or mediation, program. In addition, OSC is currently reviewing the retaliatory conduct of six managers in three locations for possible disciplinary action.

OSC currently has 279 active VA whistleblower retaliation cases in 44 states, the District of Columbia, Puerto Rico, and VA hospitals abroad. Approximately 100 of these pending cases allege retaliation for blowing the whistle on a patient health or safety concern. We will continue to update the Committee as we resolve additional cases in the coming months.

Whistleblower Disclosures

A. Process

In addition to protecting employees from retaliation, OSC also provides federal workers a safe channel to disclose violations 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. Unlike our role in retaliation complaints, OSC does not have investigative authority in disclosure cases. Rather, OSC plays a critical oversight role in agency investigations of alleged misconduct.

After receiving a disclosure from a federal employee, OSC evaluates the information to determine if there is a "substantial likelihood" that wrongdoing exists. If OSC makes a "substantial likelihood" determination, we transmit the information to the head of the appropriate agency. The agency head, or their designee, is required to conduct an investigation and submit a written report on the investigative findings. The whistleblower is given the opportunity to comment on the agency report. After we review the agency report and the whistleblower comments, we transmit them with our analysis to the President and Congress and place the information on our web site.

This process promotes accountability and is transparent. We require agencies to investigate complex wrongdoing. And, the process empowers whistleblowers, the subject matter experts in the issues they have raised, to assess the quality of the agency investigation and provide comments on the agency's report.

In recent years, the OSC disclosure process has prompted significant changes in government operations and saved taxpayer dollars. For example, whistleblower disclosures to OSC about rampant overtime abuse in the Department of Homeland Security (DHS) prompted a successful legislative effort to modernize the pay structure for Border Patrol Agents. The pay reform, spearheaded by Members of this Committee after hearings with DHS whistleblowers and OSC, saves taxpayers $100 million a year—an amount over four times the size of OSC's annual budget.

At the VA, our work with whistleblowers led to an overhaul of the VA's internal medical oversight office, the Office of the Medical Inspector (OMI), and has prompted positive changes throughout the department. VA whistleblowers identified and set in motion corrective action plans to address significant threats to the health and safety of veterans. For example, numerous whistleblowers at the Jackson, Mississippi VAMC helped to remedy chronic under-staffing in the Primary Care Unit, improper prescription of narcotics, and unsanitary medical equipment. A whistleblower at a Brockton, Massachusetts VA community living center exposed extreme shortcomings in the care provided to long-term mental health patients. And, two whistleblowers at a VA clinic in Fort Collins, Colorado, were among the first to identify manipulation of data on patient wait times. These efforts all led to positive changes at the facility involved, leading to better care for veterans.

B. Inconsistent Application of Discipline in VA Whistleblower Cases

Government-wide, OSC will receive nearly 2,000 whistleblower disclosures from federal employees in 2015.[1] At current levels VA employees will file, approximately 774, or 38 percent, of these disclosures.

As I noted in recent testimony before the Senate Appropriations Committee, whistleblower disclosures not only improve the care provided to veterans, but also help to promote accountability and deter future misconduct. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct identified by whistleblowers in disclosures to OSC.

This is substantial progress toward greater accountability and deterring future misconduct, and I applaud the VA for taking these important steps. Unfortunately, as explained below, our review of several recent disclosure cases indicates that disciplinary actions are being inconsistently imposed. The failure to take appropriate discipline, when presented with clear evidence of misconduct, can actually undermine accountability, impede progress, and discourage whistleblowers from coming forward.

I highlighted my concerns about the disciplinary action process in a September 17, 2015 letter to the President and the Chairmen of the Veterans' Affairs Committees (attached). I raised specific concerns about the lack of accountability in response to confirmed mismanagement at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Hayden VAMC), and other locations. I provided the following examples:

- At the Hayden VAMC, not a single nurse in the emergency department (ED) had completed a nationally-recognized, comprehensive triage training regimen. Only 11 of 31

[1] Each year, OSC receives a number of cases that are inadvertently filed by federal employees as disclosures of wrongdoing, and properly should have been filed as retaliation complaints because the employee is seeking to remedy a personnel action. OSC is in the process of modernizing its online complaint filing system to make it more user-friendly and intuitive. With a smarter, more user-friendly interface for federal employees, the new system will greatly diminish the historical problem of wrongly-filed disclosure forms. By diminishing the number of wrongly filed disclosure cases, the new system will provide a more accurate, but lower number of disclosure cases received in FY2016 and beyond. The changes may increase the number of retaliation complaints.

Phoenix ED nurses received any triage training at all. The in-house training completed by these 11 nurses omitted critical educational content. ED nursing supervisors nevertheless required nurses with inadequate or no training to triage incoming patients. This resulted in at least 110 cases that the whistleblower identified in which ED patients were improperly triaged and experienced dangerous delays in care. OMI concluded that the lapses in ED triage "constitute a significant risk to public health and safety" of veterans. Despite these findings, the VA has taken no disciplinary action against responsible officials.

- In Federal Way, Washington, the manager of a VA clinic falsified government records, repeatedly overstating the amount of time she spent counseling veterans. Regional leaders were aware of the manager's misconduct, yet failed to take action to address it. Although OMI substantiated both sets of allegations, the manager and regional leaders received only a reprimand, the lowest form of available discipline.

- The director of a VA outpatient clinic within the Martinsburg, West Virginia VAMC system improperly monitored witness interviews through a video feed to a conference room during an OMI investigation of patient care problems. The manager also approached a witness after the employee provided testimony to OMI and was not candid when interviewed about his actions. The director's actions create a chilling effect on the willingness of employees to participate in OMI and other investigative processes that promote better care for veterans. The director received only a written counseling.

- Officials at the Beckley, West Virginia VAMC attempted to meet cost savings goals by requiring mental health providers to substitute prescriptions for veterans, requiring them to prescribe older, cheaper, and less effective antipsychotic medications. These actions violated VA policies, undermined effective treatment of veterans, and placed their health and safety at risk. To date, no one has been disciplined.

- In Montgomery, Alabama, a staff pulmonologist copied and pasted prior provider notes for veterans, including the patients' chief complaint, physical examinination findings, vital signs, diagnoses, and plans of care, resulting in inaccurate recordings of patient health information and in violation of VA rules. An investigation confirmed that the pulmonologist copied and pasted 1,241 separate patient records. Yet the physician received only a reprimand. While the VA explained that managers attempted to issue a 30-day suspension, management apparently did not provide the appropriate information to human resources, which only approved a reprimand.

These cases stand in stark contrast to disciplinary actions taken against VA whistleblowers. My September 17, 2015 letter summarizes seven additional cases in which the VA attempted to fire or suspend whistleblowers for minor indiscretions or for activity directly related to the employee's whistleblowing. OSC has worked with VA headquarters to rescind the disciplinary actions in these cases. Nevertheless, the severity of the initial punishments chills other employees from stepping forward to report concerns.

I have encouraged VA leadership to review the cases identified and determine whether systemic changes to the disciplinary action processes in the VA would correct the inconsistent imposition of penalties. Based on the VA leadership's positive response to my prior recommendations, I am optimistic that the VA will work to appropriately address this problem.

In fact, just last week, Deputy Secretary Sloan Gibson issued a memorandum setting forth a new process for responding to OSC referrals of whistleblower information. The new process will route all OSC referrals through the VA Executive Secretariat, ensuring the highest level review of all whistleblower allegations and corresponding investigations. I am hopeful that this centralized, high-level review will address the concerns expressed in my September 17 letter and promote better and more consistent outcomes in whistleblower disclosure cases.

Additional Areas for Congressional Consideration

In prior testimony, I highlighted several ongoing areas of concern in our investigation and review of VA whistleblower cases. I previously discussed the improper accessing of whistleblowers' medical records, retaliatory investigations, and the role of regional counsel in whistleblower investigations. I would be happy to provide additional detail on each of these subjects.

Today, I want to focus on some specific measures that Congress could take to assist OSC in its investigations. OSC has not been formally reauthorized since 2007. While this does not prevent OSC from receiving appropriations, reauthorization provides Congress with an opportunity to evaluate OSC's authorities and responsibilities and make any necessary adjustments. While the Committee may want to consider any number of issues in connection with OSC reauthorization legislation, I would like to focus on two of particular importance.

First, Congress may want to clarify OSC's authority to seek information from other government agencies to assist OSC in its independent investigations of whistleblower retaliation and prohibited personnel practice claims. It would be helpful to provide OSC with direct, statutory authority to gain access to all agency information, much like the authorities Congress has provided to Inspectors General and the Government Accountability Office. Currently, OSC's authority to request documents is regulatory. Office of Personnel Management (OPM) regulation directs agencies to comply with document requests from OSC. While agencies typically comply with our OPM civil service rule 5.4 requests, we have had some difficulty in VA investigations with the timeliness and completeness of responses. Direct statutory authority would better ensure that OSC obtains all relevant facts during investigations.

Second, in light of our steadily increasing workload, especially in the number of VA whistleblower cases, Congress may want to consider the procedural requirements imposed on OSC in all prohibited personnel practice cases as a possible area for revision. Changes to section 1214 of title 5 would allow OSC to spend its limited resources on the investigation and prosecution of meritorious cases, providing OSC with the ability to generate more positive outcomes on behalf of whistleblowers, the merit system, and the taxpayers. Section 1214 currently requires OSC to provide an employee with repetitive status reports, a detailed, fact-based letter, the reason for terminating the investigation, and an opportunity to comment before OSC may close a complaint file, regardless of the merits of the complaint. In light of our

skyrocketing caseloads, these requirements require us to devote significant resources to closing non-meritorious complaints, instead of focusing on prosecuting and resolving meritorious cases. These requirements are unique to OSC.

Conclusion

We appreciate the Committee's attention to the issues we have raised and your interest in our efforts to protect and promote VA whistleblowers. I thank you for the opportunity to testify, and am happy to answer your questions.

Attachment

U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

September 17, 2015

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-14-2754

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Hayden VAMC). The Office of Special Counsel (OSC) reviewed the VA reports and provides the following summary of the whistleblower's allegations and my findings. The whistleblower, Dr. Katherine Mitchell, disclosed serious threats to the health and safety of veterans seeking care in the Hayden VAMC Emergency Department (ED). According to Dr. Mitchell, Hayden VAMC did not properly train ED nurses. Patients were harmed because nurses failed to conduct appropriate triage.

The VA's Office of the Medical Inspector (OMI) substantiated Dr. Mitchell's allegations. Specifically, at the time of OMI's investigation in 2014, the ED did not employ a single nurse who had completed a nationally-recognized, comprehensive triage training regimen. Only 11 of 31 Phoenix ED nurses had completed any triage training at all. The in-house training completed by these 11 nurses omitted critical educational content. ED nursing supervisors nevertheless required nurses with inadequate or no training to triage incoming patients. Dr. Mitchell identified at least 110 cases in which ED patients were improperly triaged and experienced dangerous delays in care, including a patient with a history of strokes waiting almost eight hours for treatment after presenting to the ED with low blood pressure. OMI concluded that the lapses in ED triage "constitute a significant risk to public health and safety" of veterans. In response to OMI's findings, Hayden VAMC initiated steps to implement comprehensive triage training protocols and improve ED staffing levels, something Dr. Mitchell first suggested in 2009, in correspondence and disclosures to senior Hayden VAMC officials.

The commitment to improve training in Phoenix is a positive and long-overdue step; however, I am concerned by the VA's decision to take no disciplinary action against responsible officials. The lack of accountability for Hayden VAMC leaders sends the wrong message to the veterans served by this facility, including those who received substandard emergency care. OSC sought additional information from the VA on its

decision not to impose discipline on any responsible officials, but the VA did not provide an adequate justification.

I have determined that the agency reports contain the information required by statute. However, the VA's failure to impose disciplinary action is troubling, given the seriousness of OMI's findings. A detailed analysis of Dr. Mitchell's disclosures, and the agency investigation and reports regarding patient care at the Hayden VAMC are included as an attachment to this letter.[1]

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As part of OSC's broader review of pending VA whistleblower disclosure cases, I have identified recent additional cases in which the VA confirmed serious misconduct brought to light by whistleblowers, yet failed to appropriately discipline responsible officials.

Similarly, in June 2014, I highlighted a pattern of deficient patient care at VA facilities nationwide, and the VA's resistance, and OMI's in most cases, to acknowledge and address the impact on the health and safety of veterans. In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. This review resulted in positive changes. With increasing consistency, patient care challenges, like those OMI identified in response to Dr. Mitchell's disclosures, are being acknowledged as threats to the health and safety of veterans, allowing the VA to consider and take the corrective actions needed to improve care for veterans.

The next and critical step is to hold officials accountable after lapses in care have been identified. Whistleblower disclosures, like those Dr. Mitchell submitted, can play a pivotal role in promoting accountability at the VA. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct that whistleblowers identified. This is substantial progress. Nevertheless, as explained below, disciplinary action is being inconsistently imposed. The failure to take appropriate discipline, when presented with clear evidence of misconduct, can undermine accountability, impede progress, and discourage whistleblowers from coming forward.

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[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations 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 and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The following examples are illustrative:

- In Federal Way, Washington, the manager of a VA clinic falsified government records, repeatedly overstating the amount of time she spent in face-to-face counseling sessions with veterans. Regional leaders were aware of the manager's misconduct, yet failed to take action to address it. OMI substantiated both sets of allegations, yet the manager and regional leaders received only a reprimand, the lowest form of available discipline.

- The director of a VA outpatient clinic within the Martinsburg, West Virginia VAMC system improperly monitored witness interviews through a video feed to a conference room during an OMI investigation of patient care problems. The manager also approached a witness after the employee provided testimony to OMI and was not candid when interviewed about his actions. The director's actions create a chilling effect on the willingness of employees to participate in OMI and other investigative processes that promote better care for veterans. Yet the director received only a written counseling.

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- In Montgomery, Alabama, a staff pulmonologist copied and pasted prior provider notes for veterans, resulting in inaccurate recordings of patient health information and in violation of VA rules. The pulmonologist copied and pasted other physicians' earlier recordings, including the patients' chief complaint, physical examination findings, vital signs, diagnoses, and plans of care. An investigation confirmed that the pulmonologist copied and pasted 1,241 separate patient records. Yet the physician received only a reprimand. While the VA explained that managers attempted to issue a 30-day suspension, management did not provide the appropriate information to human resources, which only approved a reprimand.

The lack of accountability in these cases stands in stark contrast to disciplinary actions taken against VA whistleblowers. The VA has attempted to fire or suspend whistleblowers for minor indiscretions and, often, for activity directly related to the employee's whistleblowing. While OSC has worked with VA headquarters to rescind the disciplinary actions in these cases, the severity of the initial punishments chills other employees from stepping forward to report concerns. OSC has obtained corrective action, or is working to correct the actions taken against the following employees:

- At the Philadelphia VAMC, a food services manager who blew the whistle on VA sanitation and safety practices was fired after being accused of eating four expired sandwiches instead of throwing them away.

- In Puerto Rico, the VA sought to remove an employee who blew the whistle on the hospital director's misconduct. Puerto Rico officials claimed the employee made an "unauthorized disclosure of information." But the employee's communication was protected and related to his concerns about hiring violations at the facility. The VA also sought removal of a second Puerto Rico employee, the privacy officer, in part because she concluded that the whistleblower had not made an unauthorized disclosure, and refused management pressure to change her finding.

- A VA employee in Wisconsin sent an email expressing her concerns about ongoing improper disclosures of veterans' health information. The employee sent the email to an internal list of VA privacy and compliance officers, yet the VA fired the employee for sending the email because it contained personal information about a veteran.

- The VA fired an employee and disabled veteran in Baltimore for pretextual reasons after he petitioned Congress for assistance with his own VA benefits claim.

- In Kansas City, the VA fired an employee who blew the whistle on improper scheduling practices, claiming for the first time after her disclosures that she was acting "too slowly" in scheduling appointments for veterans.

- At the Wilmington, Delaware VAMC, a registered nurse blew the whistle on improper treatment of opiate addiction. The employee received a 14-day suspension for charging one colleague $5 for notary services, an event that occurred a year prior to his whistleblowing, and other minor allegations of misconduct.

In 2015, OSC received over 2,000 cases from VA employees. The large number of VA cases OSC has received and processed provides us with the ability to compare the actions taken against whistleblowers with those taken, or not taken, against officials who engage in substantive misconduct. I highlight these cases to demonstrate the disparity in punishments for whistleblowers and those who have engaged in misconduct that negatively impacts patient care.

I encourage VA leadership to review the cases identified and determine whether systemic changes to the disciplinary action processes in the VA would correct the inconsistent imposition of penalties.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the unredacted agency reports and Dr. Mitchell's comments to the Chairmen and Ranking members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports and Dr. Mitchell's comments in our public file, which is available at www.osc.gov.[2] OSC has now closed this file.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures

[2] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.

STATEMENT OF LINDA A. HALLIDAY
DEPUTY INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
HEARING ON
IMPROVING VA ACCOUNTABILITY:
EXAMINING FIRST-HAND ACCOUNTS OF
DEPARTMENT OF VETERANS AFFAIRS WHISTLEBLOWERS
SEPTEMBER 22, 2015

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss how the VA Office of Inspector General (OIG) works to protect and encourage Federal employees to come forward with allegations of waste, fraud, abuse, and mismanagement. I am accompanied by Mr. Quentin G. Aucoin, Assistant Inspector General for Investigations.

BACKGROUND

Under Public Law (P.L.) 101-12, the *Whistleblower Protection Act of 1989*, as amended, it is unlawful for agencies to take or threaten to take a personnel action against an employee who makes a protected disclosure—information he or she reasonably believes evidences a violation of any law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific danger to public health and safety—so long as the disclosure is not specifically prohibited by law. Personnel actions can include a poor performance review, demotion, suspension, or termination. In addition, the law prohibits retaliation for filing an appeal, complaint, or grievance; helping someone else file or testifying on their behalf; or cooperating with or disclosing information to the OIG.

The OIG does not make a determination as to whether an individual who makes a complaint or provides information to the OIG has made a protected disclosure as defined under the *Whistleblower Protection Act of 1989*, as amended, and applicable case law is considered to be a "whistleblower." This is a legal determination made by the U.S. Office of Special Counsel (OSC), the U.S. Merit Systems Protection Board (MSPB), or the U.S. Court of Appeals for the Federal Circuit.

ONGOING EFFORTS TO EDUCATE AND PROTECT WHISTLEBLOWERS

As we have stated on many occasions, complainants, including whistleblowers, are the lifeline of OIG organizations, and the OIG is committed to protecting their identities, understanding their concerns, objectively seeking the truth, and ensuring VA pursues accountability and corrective action for wrongdoing. Individuals who at times risk their reputations and careers to report suspected wrongdoing should be afforded all of the protections available by law. Over the years, whistleblowers have played a vital role in

revealing serious problems in need of corrective action at VA. For example, we recently acknowledged the instrumental efforts of a whistleblower who exposed extensive, persistent data integrity issues at the Veterans Health Administration's Health Eligibility Center.[1]

Promoting Awareness about Whistleblower Protections and Retaliation Prohibitions
As authorized by P.L. 112-199, the *Whistleblower Protection Enhancement Act of 2012*, the OIG Whistleblower Protection Ombudsman program provides education about protections for current or former employees of VA, VA contractors, or VA grantees who make protected disclosures. The OIG Ombudsman cannot act as a legal representative, agent, or advocate of the employee or former employee; however, the Ombudsman coordinates with VA administrations and staff offices to increase awareness of prohibitions on whistleblower retaliation. In addition, the program disseminates information on rights and remedies against retaliation for making protected disclosures. Specifically, the Ombudsman provides complainants with information on how to contact organizations that address reprisal allegations.

Protecting the Identities of Complainants Who Contact the OIG Hotline
The OIG takes seriously the provisions of Section 7(b) of P.L. 113–126, the *Inspector General Act of 1978* (IG Act), as amended, that prohibits the disclosure of the identity of an employee who has made a complaint or provided information to the OIG unless the employee consents to the disclosure or, in very rare occasions, the VA Inspector General personally determines such disclosure is unavoidable during the course of an investigation; however, such determinations are extremely rare.

The OIG Hotline serves as the central point of contact for employees, veterans and their family members, other Federal agencies, and the general public to report allegations. When individuals contact our Hotline, they are advised of their right to submit their complaint anonymously, to identify themselves but remain confidential, or to waive the right to confidentiality, and of the potential consequences of their decision. Confidential status enables further communication between the OIG and the complainant after the original complaint is received. Confidential status is more advantageous to both the OIG and the complainant than anonymous status because it allows further contact with complainants to clarify issues and better focus of efforts.

We receive far more allegations than we have the resource capacity to review, thus the OIG must be highly selective in the cases we accept. VA is the second largest Federal employer with a fiscal year (FY) 2015 operating budget of $163.5 billion and over 351,000 employees spread throughout VA's massive, decentralized network of 144 hospitals, over 1,200 outpatient clinics, 300 vet centers, 56 regional benefit offices, and over 130 national cemeteries spread throughout every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands that serve an estimated 22 million living veterans.

[1] http://t.co/PFHJojWKzh. Accessed September 17, 2015.

The OIG receives approximately 40,000 complaints annually from employees, veterans, their families, and the general public, making our Hotline one of the largest and most active in the OIG community. We must use our professional judgment to accept only the allegations that we believe represent the most serious risks to veterans, beneficiaries, and taxpayers. This includes indicators of significant fraud, compliance failures, systemic problems in program management and financial stewardship, and improprieties by senior officials.

For allegations that are not accepted by the OIG but that appear to warrant further review, the OIG makes external referrals to VA in accordance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals* (January 15, 2009).[2] I have directed my staff to initiate a review of VA Directive 0701 to determine ways we can enhance the existing referral process and provide better service to individuals who report allegations. Further, I have a team assessing the feasibility of repositioning our resources to enable the OIG to perform more reviews of the complaints that under current procedures would be externally referred to VA, and to provide better control of the quality of the reviews performed. Because thorough investigations and reviews take time, we are specifically considering enhancing communications with complainants at interim points throughout the process.

We also apply strong controls to protect the identities of those who report allegations. For example, the OIG does not identify the complainant to VA when making these referrals without the complainant's prior written consent. In certain circumstances, such as veteran-specific complaints regarding specific episodes of VA medical care, it may be unavoidable to disclose a complainant's identity to VA in order for the allegation to be reviewed. In cases where it is not possible for VA to review the complaint without the OIG disclosing the identity of the complainant, we advise the complainant and, before taking any further action on the complaint, request that they provide their written consent for the OIG to disclose their identity. Without the proper consent, we do not proceed with an external referral.

Protecting the Identities of Complainants for Matters Outside OIG's Jurisdiction

The OIG does not evaluate complaints regarding matters that are unrelated to the programs and operations of VA or that can be addressed in other legal or administrative forums. When possible, the OIG advises the individual of the appropriate VA program office or Federal agency that can provide further assistance on the matter. For example, individuals with complaints regarding claim adjudications for VA disability and pension benefits are advised to contact the Veterans Benefits Administration (VBA); individuals with complaints regarding discrimination are advised to contact VA's Office of Resolution Management (ORM); and individuals with allegations of prohibited personnel practices, including reprisal for whistleblowing, are advised to contact OSC. As a precautionary measure to avoid an accidental unauthorized disclosure of an individual's identity, we do not provide the incoming complaint directly to the outside agency but rather provide the agency's contact information to the individual to pursue if

[2] http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=436&FTy. Accessed September 17, 2015.

he or she wishes. I have also directed my staff to assess the quality of our communications with complainants.

Providing Guidance on Responsibly Reporting Sensitive Information

Multiple Federal laws, as outlined below, protect the disclosure of certain personal information maintained in VA systems of records to a third party without the prior written consent of the individual to whom the record pertains. It is the responsibility of every VA employee, including whistleblowers, to safeguard and protect the personally identifiable information (PII) and protected health information (PHI) of veterans and fellow employees who could be harmed if the personal information became public.

PII is any information about an individual that can be used to distinguish or trace an individual's identity alone or when combined with other information that can be linked to an individual. Examples of such personal information include but are not limited to an individual's name, social security number, date and place of birth, photograph, financial transactions, and criminal or employment history. PHI includes any information that concerns the health status, provision of health care, or payment for health care that can be linked to an individual.

The improper disclosure of veterans' PII or PHI, particularly sensitive medical and mental health information, can have serious consequences for the veterans to whom the information pertains. Individuals whose information is improperly disclosed can suffer social, economic, or physical harm even including potential loss of life. Federal laws dictate that veterans have both a right and expectation that their private medical and other claims information not be disclosed without their consent unless otherwise authorized by statute.

In recognition of this, many VA employees are uncertain about whether they are permitted by law to disclose PII and PHI to the OIG. P.L. 104-191, the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), specifically authorizes the disclosure of HIPPA-protected information by individuals reporting to a health oversight agency such as the OIG; however, such disclosures must be made in a responsible manner without compromising veterans' personal information or right to privacy. For several years, the OIG's public website has included a "Frequently Asked Questions" section that specifically addresses this concern.[3] Our website instructs VA employees about how they can keep information secure when the information is protected from disclosure by law.

The OIG takes very seriously the responsibility of every VA employee to protect veterans' sensitive information, and we have a track record of investigating data losses and breaches within VA. While we strongly encourage any employee with information of wrongdoing to report it to the OIG, we equally encourage those employees to ensure they are doing so in a manner that does not compromise sensitive veteran information. An employee who blows the whistle is not immune from or an exception to enforcement

[3] http://www.va.gov/oig/hotline/faq.asp#disclose. Accessed September 17, 2015.

of these laws when making a disclosure about suspected wrongdoing if they put sensitive veteran information at risk during the course of the disclosure.

- HIPAA and the Privacy Rule (45 CFR Part 160 and Part 164, Subparts A and E) prohibit covered entities, with limited exceptions, from disclosing PHI to a third party without the prior written consent of the individual to whom the record pertains.

- P.L. 93-579, the *Privacy Act of 1974* (Privacy Act), governs the collection, storage, access to, use of, and disclosure of PII about veterans and VA employees. The Privacy Act prohibits, with limited exceptions, the disclosure of information that is maintained, or should be maintained, in a Privacy Act system of records without the consent of the individual to whom the record pertains. The term "disclosure" includes any means of communication including oral disclosures. The Privacy Act provides for civil and criminal penalties for the unauthorized disclosure of records or information contained in those records.

- Title 38 U.S.C. Sections 5701, 5705, and 7332 protect certain VA records from disclosure. As with the Privacy Act, each of these statutes include civil and/or criminal penalties for unauthorized disclosures.

    - Title 38 U.S.C. Section 5701 prohibits the disclosure of VA claims records, including the names and addresses of veterans and other beneficiaries. With the exception of deceased veterans, these records are also protected under the Privacy Act. Unlike the Privacy Act, Section 5701 is still applicable after the death of the individual.

    - Title 38 U.S.C. Section 5705 prohibits the disclosure of medical quality assurance records. Regulatory requirements implementing this statute are set forth in 38 C.F.R. 17.500 et. seq.

    - Title 38 U.S.C. Section 7332 prohibits the disclosure of records of the identity, diagnosis, prognosis, or treatment of any patient or subject that are maintained in connection with the performance of any program or activity relating to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia.

VA records can and frequently include highly confidential information which, if publicly disclosed, could cause harm not only to important processes that ensure continuous quality review and improvement, but most importantly, to veterans and their families who may have significant interests in protecting their private information.

CHALLENGES TO PROTECTING WHISTLEBLOWER IDENTITIES

Swift Response by OIG Management to Confidentiality Breaches

Fulfilling the OIG's mission requires a people-driven process and on occasion human errors occur during the course of our work. On rare occasions, we receive complaints

that OIG staff breached the confidentiality of a complainant. When this occurs, we investigate the allegations and take administrative action with our own staff when the complaint is substantiated. I am aware of only two such incidents both of which were unintentional mistakes, and actions were taken to hold staff accountable. I am not aware that there has ever been an intentional breach of a complainant's confidentiality.

Employees Who Report Their Complaint to Multiple Outlets

There are occasional instances where individuals who have requested confidentiality with the OIG have also made the same complaints to VA management, coworkers, or media outlets, or they have made statements that they have gone to the OIG or threatened to go to the OIG. Even though the OIG does not disclose the identity of the complainant, either overtly or by refusing to confirm that the individual submitted a complaint, VA officials know or, at a minimum suspect, that the individual filed the complaint. Furthermore, under certain circumstances, the very nature of the allegations brought forth by the complainant may render the complainant's identity obvious or possible to deduce by others outside the OIG.

RECENT INITIATIVES

I assumed the position of Deputy Inspector General (IG) on July 6, 2015. On July 10, 2015, I announced that one of my first acts as Deputy IG would be to ensure that all OIG employees are fully trained on protections and remedies guaranteed to Federal employees by the *Whistleblower Protection Act of 1989*, the *Whistleblower Protection Enhancement Act of 2012*, and related laws. To this end, the OIG has registered with OSC to participate in the OSC's 2302(c) Certification Program and expects to complete all required actions for certification by December 2015. OSC presented the first training session on September 16, 2015, to approximately 25 percent of OIG staff. Undertaking the certification process will help strengthen our past training efforts so that all OIG employees—from our Hotline analysts who are a complainant's first point of contact with the OIG to our auditors, investigators, and healthcare inspectors who interact with complainants in the course of their daily work activities—can assist complainants in making protected disclosures and by educating them on their right to be free from retaliation for whistleblowing and other prohibited personnel practices.

I have also taken several actions to further strengthen the OIG's Whistleblower Protection Ombudsman program.

Improved Hotline Submission Process

In order to better serve complainants and address complainant concerns of potential retaliation in an informed manner, we have created additional forms on our website designed to ensure anonymity, confidentiality, or allow for full identity disclosure. Providing these different classifications allows complainants a greater degree of confidence that their personal information is appropriately protected. We also rewrote in plain English the notice Hotline sends to individuals who contact us so that there is a clear understanding of what to expect when making a complaint.

Reinvigorated the OIG Rewards Program
To promote greater utilization of the OIG's cash reward program to individuals who disclose information leading to felony charges, monetary recovery, or significant improvements to VA operations or programs, each OIG Directorate and the OIG Whistleblower Ombudsman will proactively conduct a semiannual review of disclosures made to the OIG to identify potential recipients for cash rewards. Rewards will be based on such factors as the significance of the information, risks to the individual making the disclosure, time spent and expenses incurred by the individual making the disclosure, and cost savings to VA.

Later this year, we will recognize a vocal advocate of better Government who was instrumental in supporting OIG's efforts to pursue allegations of criminal activity, fraud, waste, abuse, and mismanagement of operations at a VA Regional Office (VARO) at a public presentation. In addition to personally providing valuable information pointing to gross mismanagement, the individual encouraged other colleagues to do the same in a review completed in 2015. With the assistance of this individual and the evidence provided, OIG substantiated serious issues at the VARO.

Enhanced Crime Awareness Education Briefings
These briefings, provided by our criminal investigators as part of cyclical inspection reviews of VHA and VBA facilities, will be expanded to better define how VA employees can make disclosures of protected health information, the roles and responsibilities of the Whistleblower Protection Ombudsman, and the avenues of relief available to VA employees. For the period FY 2014 to present, more than 300 briefings were attended by approximately 20,000 VA employees nationwide. Implementation of this training in VA's work environment can potentially reduce reprisal actions that whistleblowers have previously experienced.

CONCLUSION
The OIG recognizes the critical role complainants and whistleblowers play in exposing serious problems and deficiencies in VA programs and operations, and I will continue to review and evaluate ways in which the OIG can enhance its interactions with complainants. We are committed to protecting the identity of any person who comes forward to the OIG to report serious allegations of criminal activity, fraud, waste, abuse, and mismanagement; getting to the bottom of those allegations; and monitoring VA to ensure they pursue accountability and corrective action when wrongdoing is found. OSC has found that VA whistleblowers have experienced reprisal actions, and that those actions are inappropriate. Whistleblowers have raised valid and important concerns to our organization. Their concerns regarding reprisals cannot be taken lightly. As we move forward it is my hope that OSC will continue to actively investigate complaints of such reprisal actions to the fullest extent possible and that VA will hold accountable any VA official who engages in retaliatory actions.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions that you or Members of Committee may have.

STATEMENT OF
DR. CAROLYN CLANCY
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
U.S. SENATE

SEPTEMBER 22, 2015

Good afternoon, Chairman Johnson, Ranking Member Carper, and Members of the Committee. Thank you for inviting us here today to discuss ways that Congress and VA can further encourage Federal employees to come forward with their concerns regarding quality; patient safety; and waste, fraud, and abuse.

VA exists to serve Veterans. This service takes place through interactions between Veterans and front-line VA employees – physicians, nurses, and other clinicians in VA hospitals; claims processing staff in regional benefits offices; cemetery workers; and countless others – upon whom VA depends to serve Veterans with the dignity, compassion, and dedication they have earned and deserve. We depend on these employees to be vigilant about actual and potential sources of harm to patients, and to voice their concerns if a patients' safety is at risk. In fact, providing safe, high-quality health care is not possible unless caregivers voice their concerns. Within this context, the Department's responsibility to protect whistleblowers is an integral part of our obligation to provide safe, high-quality health care. Retaliation against whistleblowers who have demonstrated the moral courage to share their concerns is unacceptable and cannot be tolerated. Protecting whistleblowers from retaliation is a key component of carrying out VA's core mission in accordance with its institutional core values (integrity, commitment, advocacy, respect, excellence – I CARE). Veterans expect VA leadership to cultivate an environment that empowers our employees and demands accountability in service to our Veterans. VA is making progress, and under Secretary McDonald's leadership, we will reach our goal of ensuring that every employee feels safe in raising concerns, and is protected from any retaliation when they choose to do so.

The witnesses you are hearing from firsthand today underscore the importance of ensuring that all Veterans receive the highest quality of medical care. VA recognizes the important role that whistleblowing plays in bringing issues to light. For example, as you may know, I was and am personally invested in ensuring that the quality of care at Tomah VA Medical Center (VAMC) is of the highest order and that any and all circumstances that led to problems at the Tomah VAMC have been diagnosed and fixed. I met with whistleblowers in Tomah, as I have at other facilities throughout our system. Any health care system requires a wide array of feedback from multiple sources to ensure the best possible clinical outcome for patients. In addition to the many formal feedback mechanisms VHA has built into our system, as the Secretary has made clear, we need and want all employees and Veterans to feel empowered to provide a firsthand account of their experiences, so that we can identify and rectify any problems. It is important to keep in mind that just as in Tomah, the underlying purpose of whistleblower protection rules is to encourage the candid disclosure of information about problems, so that deficiencies are corrected and unsafe or unlawful behavior is quickly corrected. Of necessity, there are legal disciplinary options in terms of penalties for supervisors who retaliate against whistleblowers, but the penalties exist to support the primary focus on information flow and quality, safety, or process improvement. VA is fully committed to correcting deficiencies in its processes and programs, and to ensuring fair treatment for whistleblowers who bring these deficiencies to light. Secretary McDonald consistently communicates about his vision of "sustainable accountability," which he describes as a workplace culture where VA leaders provide the guidance and resources employees need to successfully serve Veterans, and employees are empowered and encouraged to inform VA leaders when challenges hinder their ability to succeed. We need a work environment in which all participants – from front-line staff through lower-level supervisors to senior managers and top VA officials – feel safe sharing what they know, whether good news or bad, for the benefit of Veterans and as good stewards of the taxpayers' money.

In recent months, the Department has taken several important steps to improve the way we address operational deficiencies, and to ensure that those who disclose such deficiencies are protected from retaliation. In July 2014, Secretary McDonald

reorganized and assigned new leadership to the VA Office of the Medical Inspector (OMI), the internal oversight component of VHA that reviews whistleblower disclosures related to VA health care operations. OMI moved quickly to establish clear policies that ensure that whistleblower allegations are investigated objectively, thoroughly, and promptly. Since that time, OMI has completed 30 new whistleblower investigations and prepared more than a dozen supplemental reports to follow up on earlier investigations at the request of the U.S. Office of Special Counsel (OSC), the independent office responsible for overseeing whistleblower disclosures and investigating whistleblower retaliation across the Federal government. When the investigation substantiates the whistleblower's allegations, OMI works closely with OSC and the responsible VHA officials to track the status of corrective actions to completion.

VA has also improved its collaboration with OSC in other ways. Recently the Department sent VA's Office of General Counsel and OAR personnel to OSC to attend training on investigating whistleblower retaliation cases. This training was then disseminated to all OAR investigators. Additionally, the first week of November, OAR Investigators will train a select number of Regional Counsel Attorneys and Senior Human Resources professionals from the field on how to conduct whistleblower retaliation investigations so they may expand the ranks of personnel who can be assigned to this type of investigation.

Last summer, VA negotiated with OSC a process that provides for prompt corrective action for cases where after a brief initial fact-finding effort, whistleblowers appear to have been subjected to retaliation. The process is referred to as the "expedited process" because relief is provided to whistleblowers quickly, within weeks of referral, before a thorough in-depth investigation is undertaken by either OSC or VA to make culpability determinations, which would take several months. This novel approach allows OSC and VA to work together to reduce duplicate investigations and to protect whistleblowers from retaliation in a more timely manner. As of September 9, 2015, VA had received 22 expedited cases, so far. VA has received these cases on an ongoing basis since the process was established. We have successfully resolved 11 cases, denied four, two were withdrawn by the OSC, and five are pending. For the cases that have been resolved, it has taken an average of 30 to 60 days to complete. Cases

resolved under the expedited process are then forwarded to OAR for full investigation, as are all OSC referrals. VA understands that we can improve on the timeliness on ensuring individuals found responsible for retaliation, whether brought to light through the expedited process or through traditional channels, are disciplined appropriately. One approach to ensuring that investigations into retaliation are completed more timely and in more direct correlation with OSC's charge is for Congress to fund OSC at a level that enables the office to hire more investigators to complete this work. OSC has traditionally fulfilled this charge and increasing their staffing to a level to assist VA in this endeavor would allow VA's limited investigative assets to focus more in VA's areas of expertise. Investigating allegations of wrong-doing, especially where patient care is potentially impacted, requires the preponderance of our current limited resources. It is extremely important that VA hold an individual guilty of retaliation accountable for their actions. We welcome OSC's additional assistance on this front.

In previous Congressional Testimony, the VA has highlighted several additional steps to improve how we address operational deficiencies, and to ensure that those who disclose such deficiencies are protected from retaliation. Some of these examples include:

- Completing all requirements for certification under OSC 2302(c) certification program;
- Providing formal VA leadership communication to all employees regarding the importance of whistleblower protection, emphasizing that managers and supervisors are responsible for enforcing whistleblower protection laws; and
- Requiring annual training by all senior executives (Course title: "Whistleblower Rights and Protection and Prohibited Personnel Practices").

Secretary McDonald, Deputy Secretary Gibson, and other VA Senior Leaders, including myself, have made it their practice to meet with whistleblowers when they travel to VA facilities, and to engage with those who have raised their hands and their voices to identify problems and propose solutions. VA's Senior Leadership does this to acknowledge the critical role whistleblowers play in improving the quality, safety, and effectiveness of VA programs, and to model to supervisors VA-wide the engaged, open,

and accepting behavior they expect them to exhibit when subordinates express concerns.

The Department has had problems ensuring that whistleblower disclosures receive prompt and effective attention, and that whistleblowers themselves are protected from retaliation. I acknowledge today that VA is still working toward the full culture change we must achieve to ensure that all employees feel safe disclosing problems, and that all supervisors who engage in retaliatory behavior are held promptly and meaningfully accountable. VA continues to work with whistleblowers, OSC, and Congress to resolve these issues, and we remain deeply committed to these endeavors. Again, we would welcome additional assistance from OSC in more fully conducting retaliation investigations, and hope that Congress will fund them accordingly.

Mr. Chairman, this concludes my testimony. We look forward to answering the Committee's questions.