Testimony of
Lydia Dennett, Investigator
Project On Government Oversight
before the Senate Committee on Appropriations
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
November 6, 2015

Chairman Kirk, thank you for inviting me to testify today, as well as for your leadership and ongoing interest in the care of our veterans. I am Lydia Dennett, an Investigator at the Project On Government Oversight (POGO). Founded in 1981, POGO is a nonpartisan independent watchdog that champions good government reforms. POGO's investigations into corruption, misconduct, and conflicts of interest achieve a more effective, accountable, open, and ethical federal government.

Fear and Retaliation at the Department of Veterans Affairs

I want to first point out that if it were not for whistleblowers, none of us would be aware of the extent of the problems at the Department of Veterans Affairs. Early last year, whistleblowers came forward to expose that managers at the Phoenix, Arizona, VA facility were falsifying records of extensive wait times in order to get personal bonuses.[1] Quickly, news of similar wrongdoing at VA facilities began to pop up in other parts of the country. Although POGO had never investigated the operations of the Department of Veterans Affairs before, we were deeply concerned about what we were seeing in these reports. In an unusual move for us, POGO held a joint press conference with Iraq and Afghanistan Veterans of America asking whistleblowers within the VA to share with us their inside perspective in order to help us better understand the issues the Department was facing.

In our 34-year history, POGO has never received as many submissions from a single agency. In little over a month, nearly 800 current and former VA employees and veterans contacted us. We received credible submissions from 35 states and the District of Columbia.[2] A recurring and fundamental theme became clear: VA employees across the country feared they would face repercussions if they dared to raise a dissenting voice. But they came forward anyway—the sheer number was overwhelming. I want to emphasize this important point: this means there were extraordinary numbers of people who work inside the VA system who care so much about the

[1] Scott Bronstein, Drew Griffin and Nelli Black, "Phoenix VA officials put on leave after denial of secret wait list," CNN, May 1, 2014. http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/ (Downloaded July 27, 2015)
[2] Statement for the Record, Project On Government Oversight (POGO), for the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations Hearing on "Addressing Continued Whistleblower Retaliation Within VA," April 13, 2015. http://www.pogo.org/our-work/testimony/2015/pogo-provides-statement-for-house-hearing-on-va-whistleblowers.html

mission of the Department that they were still willing to risk their livelihood to come forward in order to fix it.

Based on what POGO learned from these whistleblowers, we wrote a letter to Acting VA Secretary Sloan Gibson in July last year, highlighting three specific cases of current or former employees who agreed to share details about their personal experiences of retaliation.[3]

From right here in Illinois, at the Hines VA Medical Center, we received several allegations of scheduling manipulations. These whistleblowers described VA staff members improperly canceling and rescheduling veteran appointments, as well as fake waiting lists hiding the fact that some vets were waiting four or more months for an appointment. The majority of the current or former Hines employees decided to remain anonymous out of fear of retaliation. One stated, "I can't reveal my name as I fear retribution from my supervisors and other staff members….I need my job, and would surely lose it for telling you any of this."

In California, a VA inpatient pharmacy supervisor was placed on administrative leave and ordered not to speak out after raising concerns with his supervisors about "inordinate delays" in delivering medication to patients and "refusal to comply with VHA [Veterans Health Administration] regulations."[4] In one case, he said, a veteran's epidural drip of pain control medication ran dry, and in another case, a veteran developed a high fever after he was administered a chemotherapy drug after its expiration point.

In Pennsylvania, a former VA doctor was removed from clinical work and forced to spend his days in an office with nothing to do, he told POGO. This action occurred after he alleged that, in medical emergencies, physicians who were supposed to be on call were failing or refusing to report to the hospital. The Office of Special Counsel (OSC) shared his concerns, writing "[w]e have concluded that there is a substantial likelihood that the information that you provided to OSC discloses a substantial and specific danger to public health and safety."[5]

In Appalachia, a former VA nurse was intimidated by management and forced out of her job after she raised concerns that patients with serious injuries were being neglected, she told POGO. In one case she was reprimanded for referring a patient to the VA's patient advocate after weeks of being unable to arrange transportation for a medical test to determine if he was in danger of sudden death. "Such an upsetting thing for a nurse just to see this blatant neglect occur almost on a daily basis. It was not only overlooked but appeared to be embraced," she said. She also pointed out that there is "a culture of bullying employees….It's just a culture of harassment that goes on if you report wrongdoing," she said.

That culture clearly isn't limited to just one or two VA clinics. Some people, including former employees who are now beyond the reach of VA management, were willing to be interviewed by

[3] Letter from Project On Government Oversight to Sloan D. Gibson, then-Acting Secretary of the Department of Veterans Affairs, about Fear and Retaliation in the VA, July 21, 2014. http://www.pogo.org/our-work/letters/2014/pogo-letter-to-va-secretary-about-va-employees-claims.html

[4] Letter from Kelly Robertson, Pharmacy Service Chief at Palo Alto VA Health Care System, to Earl Stuart Kallio, Pharmacy Service, about Direct Order—Restricted Communication, June 20, 2014.

[5] Letter from Karen Gorman, Deputy Chief, Disclosure Unit Office of Special Counsel, to Dr. Thomas Tomasco, about Dr. Tomasco's allegations OSC File No. DI-13-0416, March 21, 2013.

POGO and to be quoted by name, but others said they contacted us anonymously because they are still employed at the VA and are worried about retaliation. One put it this way: "Management is extremely good at keeping things quiet and employees are very afraid to come forward."

This kind of fear and suppression of whistleblowers who report wrongdoing often culminates in larger problems, as the VA has been experiencing.

VA employees who have concerns about management or fear retaliation are supposed to be able to turn to the VA's Office of Inspector General (OIG). But whistleblowers had come to doubt the VA IG's willingness to protect them or to hold wrongdoers accountable.

Oversight at Its Worst

These fears appear to be well-founded. In May 2014, the VA IG's office issued an administrative subpoena to POGO that was little more than an invasive fishing expedition for whistleblowers who had come to us in confidence. The IG demanded "All records that POGO has received from current or former employees of the Department of Veterans Affairs, and other individuals or entities."[6] Though POGO refused to comply with the subpoena, such an action was cause for concern for many of the whistleblowers who had shared information with us. We believe this extraordinary step created an understandable chilling effect, and the number of VA whistleblowers coming to POGO slowed to a trickle in the following months.

In June of this year, the VA IG's office attacked POGO again. In an unusual step, the VA OIG submitted a statement to the Senate Homeland Security and Governmental Affairs Committee raising concerns about POGO's investigation into the VA.[7] However, the OIG could provide almost no relevant or specific evidence to support its own claims or rebut POGO's arguments. The very next day the VA OIG sent a white paper to all HSGAC members as well as 22 other Members of Congress publically attacking victims and whistleblowers at the VA Medical Center in Tomah, Wisconsin.[8]

Less than a month later, Acting Inspector General Richard Griffin suddenly stepped down from his position. We were pleased to see that the new Acting IG, Linda Halliday, released two statements detailing steps she plans to take to improve the IG's whistleblower protection program, including seeking certification by the Office of Special Counsel.[9]

---

[6] Letter from Richard Griffin, then-Acting Inspector General, Department of Veterans Affairs, to Project On Government Oversight, regarding subpoena to POGO, May 30, 2014.

[7] Department of Veterans Affairs, Office of Inspector General, statement regarding the Senate Homeland Security and Governmental Affairs Committee's hearing, "Watchdogs Needed: Top Government Oversight Investigators Left Unfilled for Years," submitted on June 25, 2015, p. 3. http://www.pogoarchives.org/m/va_oversight/va_oig_statement_for_record_20150603.pdf

[8] Department of Veterans Affairs, Office of Inspector General, "OIG Releases White Paper on Evidence Supporting Administrative Closure of 2014 Tomah, WI, VA Medical Center Inspection on Opioid Prescription Practice," June 4, 2014. (Downloaded July 22, 2015)

[9] Linda Halliday, Department of Veterans Affairs, Office of Inspector General, "Deputy Inspector General Announces Steps to Strengthen Whistleblower Protection Training for OIG Employees," July 10, 2015. http://www.va.gov/oig/pubs/press-releases/VAOIG-WhistleblowerProtectionsPressRelease.pdf (Downloaded July 22, 2015); Linda Halliday, Department of Veterans Affairs, Office of Inspector General, "Deputy Inspector General Announces Steps to Strengthen OIG Whistleblower Protection Ombudsman Program,"

Furthermore, at the request of Chairman Kirk, Acting IG Halliday dropped the subpoena against POGO. We greatly appreciate Chairman Kirk's continued support and applaud his commitment fixing these issues at the VA, perhaps best evidenced by the VA Patient Protection Act he introduced just this week.

VA Patient Protection Act

The cultural shift that is required inside the Department of Veterans Affairs cannot be accomplished without legislation that codifies accountability for those who retaliate against whistleblowers. This important piece has been missing in other pending VA legislation but is one of the strongest aspects of Chairman Kirk's VA Patient Protection Act.

This bill would punish VA supervisors who have been found to take retaliatory actions against whistleblowers, first with a 12-day unpaid suspension, and if a second offense is committed, the removal of the supervisor. Additionally we are glad to see that how supervisors handle whistleblower complaints will be included as criteria for their annual review, and that bonuses will not be awarded to those who have retaliated against whistleblowers.

Preventing retaliation is also key to fixing the culture at the VA. We are pleased to see that The VA Patient Protection Act requires annual training for all VA employees on prohibited personnel actions, which includes retaliating against whistleblowers as a prohibited action. Further, VA employees will receive an explanation of all the methods they can use to report wrongdoing. This bill would also create a new formal process for VA whistleblowers to file complaints within the VA, to be handled by a new Central Whistleblower Office, separate from the VA's General Counsel Office. This office will be required to report to Congress the number of complaints filed and how the Secretary addressed those complaints.

It is POGO's hope that this legislation will ensure that whistleblowers can step forward to expose wrongdoing, confident that it will not result in retaliation.

Recommendations

In POGO's 2014 letter, we recommended concrete steps incoming VA Secretary McDonald could take in order to demonstrate an agency-wide commitment to changing the VA's culture of fear, bullying, and retaliation. Neither then-Acting Secretary Sloan Gibson nor Secretary McDonald responded to our multiple requests for a meeting.

POGO also recommended that Secretary McDonald make a tangible and meaningful gesture to support those whistleblowers who have been trying to fix the VA from the inside. Once the OSC has identified meritorious cases, Secretary McDonald should personally meet with those whistleblowers and elevate their status from villain to hero. These employees should be publicly celebrated for their courage, and should receive positive recognition in their personnel files, including possibly receiving the types of personal bonuses that managers who had been falsifying records received in the past. This should not be an isolated event done in response to

---

http://www.va.gov/oig/pubs/press-releases/VAOIG-%20Ombudsmen-%2007-15-15.pdf (Downloaded July 22, 2015)

recent criticisms but an ongoing effort. Whistleblowing must be encouraged and celebrated or wrongdoing will continue.

Although then-Acting Secretary Gibson did attend an OSC event honoring VA whistleblowers, such high-profile recognition of whistleblowers needs to take place at the VA facilities themselves. For the culture at the VA to change, we believe this is a simple but meaningful step.

Additionally, the VA still does not have a permanent IG in place. That position has been vacant for over 670 days—over a year and a half.[10] Our own investigations have found that the absence of permanent and competent leadership can have a serious impact on the effectiveness of an IG office.[11] Acting IGs do not undergo the same kind of extensive vetting process required of permanent IGs, and as a consequence usually lack the credibility of a permanent IG. Acting IGs also often seek appointment to the permanent position, which can compromise their independence by giving them an incentive to curry favor with the White House and the leadership of their agency.[12] Perhaps most worrisome, given the significant challenges facing the VA IG, a 2009 Southern California Law study found that vacancies in top agency positions promote agency inaction, create confusion among career employees, make an agency less likely to handle controversial issues, result in fewer enforcement actions by regulatory agencies, and decrease public trust in government.[13] POGO urges the Senate to vet and, if qualified, confirm President Obama's nomination for a permanent VA IG as soon as possible.

On the other hand, the OSC has been working to investigate claims of retaliation and get favorable actions for many of the VA whistleblowers who have come forward. In 2014 and 2015 alone, the OSC has achieved favorable actions for 116 VA whistleblowers. But the OSC still has nearly 100 pending VA reprisal cases for disclosing concerns about patient care or safety, among the highest of any government agency, according to Special Counsel Carolyn Lerner.[14] POGO recommends that Congress consider appropriating additional funds to this agency to help with the increased workload.

But it's not just the OSC, VA Secretary, or IG who can work to fix this problem. Congress should enact legislation, like Chairman Kirk's VA Patient Protection Act, to increase protections for VA whistleblowers and hold their retaliators accountable.

POGO also urges Congress to extend whistleblower protections to contractors and veterans who raise concerns about medical care provided by the VA. POGO's investigation found that both of these groups also fear retaliation, which prevents them from coming forward. Contractors are only currently protected under a pilot program, but need permanent statutory protections. In

---

[10] Project On Government Oversight, "Where Are All the Watchdogs?" http://www.pogo.org/tools-and-data/ig-watchdogs/go-igi-20120208-where-are-all-the-watchdogs-inspector-general-vacancies1.html

[11] Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs? Addressing Inspector General Vacancies," May 10, 2012. (Hereinafter Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs?")

[12] Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs?"

[13] Anne Joseph O'Connell, "Vacant Offices: Delays in Staffing Top Agency Positions," *Southern California Law Review*, Vol. 82, 2009.

[14] Testimony of Carolyn Lerner, Special Counsel U.S. Office of Special Counsel on "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers," September 22, 2015. http://www.hsgac.senate.gov/hearings/improving-va-accountability-examining-first-hand-accounts-of-department-of-veterans-affairs-whistleblowers (Downloaded November 2, 2015)

addition, a veteran who is receiving poor care should be able to speak to his or her patient advocate without fear of retaliation, including a reduction in the quality of health care. Without this reassurance, there is a disincentive to report poor care, allowing it to continue uncorrected.

The VA and Congress must work together to end the culture of fear and retaliation. Whistleblowers who report concerns that affect veteran health must be lauded, not shunned. And the law must protect them.

The government has failed in its sacred responsibility to care for our veterans. It is our collective duty to help the whistleblowers who have taken risks to fix this broken agency.