

**STATEMENT OF THE HONORABLE DR. TAMARA BONZANTO  
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OFFICE OF ACCOUNTABILITY & WHISTLEBLOWER PROTECTION  
DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE  
HOUSE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES**

**OCTOBER 29, 2019**

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to testify today.

**I. BACKGROUND**

The Department of Veterans Affairs (VA) appreciates the opportunity to answer questions and report progress about its implementation of the VA Accountability and Whistleblower Protection Act of 2017 (the Act), Public Law 115-41. The Act, which is an unprecedented piece of legislation, is an important priority for the Department. The Act is another tool to help VA hold employees accountable and protect whistleblowers who report wrongdoing. VA's Office of Accountability and Whistleblower Protection (OAWP) was established by the President of the United States on April 27, 2017, under Executive Order 13793. OAWP was statutorily established by the Act, and its functions are codified under section 323 of title 38 of the United States Code (U.S.C.).

OAWP receives and investigates allegations of misconduct, poor performance, and whistleblower retaliation against VA senior leaders; and allegations of whistleblower retaliation against VA supervisors. OAWP also receives whistleblower disclosures from VA employees and applicants for VA employment and refers those allegations for investigation within VA. OAWP is responsible for tracking and confirming VA's implementation of recommendations from audits and investigations carried out by OIG, VA's Office of the Medical Inspector (OMI), the U.S. Office of Special Counsel (OSC), and the U.S. Government Accountability Office (GAO). OAWP is also responsible for advising the Secretary of Veterans Affairs on accountability and for identifying trends based on data received by OAWP, so that VA can proactively address systemic issues.

Trust is an important element for ensuring OAWP's success. Individuals who report wrongdoing must trust OAWP with their information. Those individuals must also trust OAWP to review and refer or investigate their allegations in a thorough and timely manner.

Since my appointment in January 2019, I have heard from Veterans, VA employees, whistleblowers, and Congress about their concerns with OAWP operations and concerns about OAWP staff. As I assessed OAWP operations, I came to the realization that most of these concerns were valid. By April 2019, I identified several deficiencies that are now highlighted in an OIG report, which needed to be corrected, including staff who were making decisions on my behalf with little to no oversight; teams who were duplicating efforts; investigators who were conducting investigations without sufficient training; a lack of communication with whistleblowers about the status of their

matters; a lack of written policies and standard operating procedures; and reports and recommendations that displayed a lack of training. Fixing these deficiencies is the first step towards regaining the trust that individuals who report wrongdoing place with OAWP. Ensuring that the information provided by those individuals is not used without their consent or as otherwise permitted by law, is also essential to regaining the trust that OAWP needs to succeed as an organization.

## **II. OVERCOMING CHALLENGES**

Since my appointment, OAWP independently identified many of the issues now substantiated by the OIG in its report issued on October 24, 2019. These issues can be attributed to a lack of oversight, communication, and training for staff. Ten of the 22 recommendations made by OIG have been addressed. VA is working to resolve the remaining six recommendations.

The Act's establishment of OAWP is to ensure a culture of accountability in VA. Unfortunately, as OIG recognized, OAWP lacked its own culture of accountability for its first 2 years of operations as reflected in the deficiencies I noted above. I am expeditiously undertaking actions to ensure that such a culture exists within OAWP. Significantly, these deficiencies identified by the OIG have an impact on VA employees who report wrongdoing. In many instances, individuals who lost their jobs or faced other forms of whistleblower retaliation relied on OAWP to conduct a thorough investigation into their allegations, only to be disappointed when staff failed to respond back to them. This lack of oversight, communication, and training for staff contributed to the lack of trust that individuals have in OAWP.

Once I assessed OAWP's deficiencies, I immediately began working to correct them, including the following:

- Reviewing all OAWP recommendations, including recommendations for disciplinary action, or no action before a case could be closed;
- Implementing an information system to track investigations and OAWP's recommendations. This system has an audit trail and ensures that only authorized users can access certain case files. This system will also help OAWP identify trends, as required by the Act;
- Stopping OAWP contractors from performing work unrelated to OAWP's statutory functions;
- Mandating that staff update whistleblowers about the status of their matters;
- Realigning OAWP's operations to ensure that teams were not duplicating efforts and to increase the number of investigators;<sup>1</sup>
- Providing OAWP investigators with training on conducting investigations. OAWP is currently developing a customized investigative training course for its investigators. This training would resolve recommendation 8 in OIG's report; and
- Issuing VA Directive 0500, *Investigation of Whistleblower Disclosures and Allegations Involving Senior Leaders or Whistleblower Retaliation*. The directive governs how OAWP receives whistleblower disclosures;

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<sup>1</sup> A pre- and post-realignment organizational chart can be found in exhibit 1.

allegations of senior leader misconduct, poor performance, and whistleblower retaliation; and allegations of whistleblower retaliation against supervisors. The directive covers a number of the recommendations made by the OIG.

I also recognize the need for appropriate oversight within OAWP. With that in mind, OAWP is working to fill its supervisory vacancies. OAWP recently hired a deputy director for investigations and two supervisory investigators. These individuals, who come from the Department of Defense and other Federal agencies, have substantial experience with managing administrative investigators; conducting whistleblower retaliation investigations; and developing whistleblower retaliation training.

I appreciate the concerns raised by OAWP employees to me about the organizational changes underway. Many of these changes are significant and represent a fundamental adjustment in the direction that OAWP was taking during its first 2 years. As we work to improve OAWP, I want to ensure that employees are engaged in these organizational changes.

I have met with several employees about their concerns and have discussed the organizational changes underway with staff during town-hall sessions. By the end of the year, OAWP will also establish employee workgroups within OAWP to solicit feedback as OAWP continues to improve its operations. The workgroups include a training workgroup, which would provide feedback on training that is beneficial for OAWP staff; a policy/process workgroup, which would provide feedback on internal standard operating procedures and policies; an employee engagement workgroup, which would advise on ways to improve employee engagement; and a technology workgroup, which would advise on ways to better utilize technology in OAWP.

The above actions, once addressed, will help strengthen OAWP workforce engagement and satisfaction as we continue to improve OAWP operations.

### **III. IMPROVING OAWP INVESTIGATIONS**

OAWP has a backlog of investigative cases, which can be defined as a disclosure or submission that is open with OAWP for over 120 days. Many of these backlogged cases date back to 2017 and 2018. The goal is to eliminate the backlog by the end of the next calendar year and, per VA Directive 0500, to have OAWP investigations conducted and recommendations issued within 120 days from the date that a disclosure or submission is received by OAWP. This newly established timeline would decrease the average time to conduct an investigation by 44 percent. To reach these goals, OAWP has undertaken a multi-prong approach, outlined below.

#### **A. Increasing the number of OAWP investigators.**

In August 2019, OAWP realigned resources to avoid a duplication of efforts on investigative cases and ensure that we have more investigators available. The realignment was based on input provided by OAWP managers and a workload analysis of a sampling of OAWP staff.

With the realignment, OAWP now has 40 investigators rather than 30. Investigators are also supervised in smaller teams of approximately 10 individuals, to ensure appropriate oversight. Since the realignment, investigators carry an average of

6 investigations. This increase in investigative case load brings them on-par with investigators who handle equally complex work in other government investigative bodies.

**B. Issuing policy to clearly define OAWP's investigatory scope.**

VA Directive 0500 was issued. The directive governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct, poor performance, and whistleblower retaliation; and allegations of whistleblower retaliation against supervisors. The directive clearly defines what is within and outside OAWP's investigatory scope.

**C. Comprehensive training to improve the quality of investigations.**

OAWP is developing a comprehensive training program for its investigators.<sup>2</sup> The program will cover investigative techniques, including report writing. The program will incorporate best practices from the Office of Special Counsel (OSC), the Council of Inspectors General on Integrity and Efficiency (CIGIE), and other governmental and non-governmental offices. This program will serve as the foundation for continuous professional training and development that will be conducted throughout this fiscal year.

**D. Developing standard operating procedures to ensure clear consistency.**

OAWP is developing standard operating procedures (SOP) and templates for investigators and staff, which are expected to be completed before the end of the calendar year. This will ensure that investigative reports, evidence gathering techniques, and interview techniques are standardized across OAWP's 40 investigators.

**E. Utilizing contractors to assist with investigations.**

Given the significant backlog, OAWP also plans to utilize contractors to assist in conducting investigations. This is a best-practice utilized by other investigative entities.

**F. Establishing a team to conduct quality reviews on investigations.**

Recognizing that quality control is essential, I have established an independent team to ensure investigative reports are thorough and accurate. This team received initial training on reviewing investigative reports in September 2019. OAWP is developing a comprehensive training program for individuals on the team to ensure that investigations are done in a fair, unbiased, thorough, and objective manner. The program will incorporate best practices from OSC, CIGIE, and other governmental and non-governmental offices. The quality review team is also developing SOPs, checklists, and a reporting template to ensure consistent quality and timeliness with OAWP investigations.

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<sup>2</sup> OAWP investigators have already been provided with standardized investigation training in August and September 2019. This supplements training that they received in the past but does not amount to a comprehensive training program. In prior years, OAWP investigators took different training courses on investigative techniques. This resulted in disparate investigative reports and interviews. For example, some investigators took a five-day investigative training course conducted by U.S. Immigration and Customs Enforcement (ICE). However, only two of the days in the course were applicable to OAWP investigators. The remaining three days focused on ICE practices and policies.

#### **G. Ensuring that disciplinary action recommendations comply with the Act.**

Starting in April 2019, all recommendations, whether for disciplinary action or no action, are reviewed by me or my designee. During my review of these recommendations, I identified several deficiencies, including the following:

- Citing investigative reports where witnesses were not interviewed;
- Conclusory statements that were not tied into evidence; and
- Failing to properly address the elements required for whistleblower retaliation.

In August 2019, OAWP developed checklists to ensure that investigative reports and recommendations did not contain these types of deficiencies. Quality staff have identified discrepancies in over 45 cases submitted to them as of September 2019. All cases where deficiencies were found were routed back to investigations for further review and resolution of the discrepancies.

The Secretary and I recognize the intent for transparency behind 38 U.S.C. § 323(f)(2), which requires that VA report to Congress when disciplinary recommendations that I make are not implemented. To memorialize our commitment to the Act, VA Directive 0500 requires Under Secretaries, Assistant Secretaries and other Key Officials, and their designees, to respond to OAWP recommended disciplinary actions, including providing a copy of the action taken or proposed and, if the recommended disciplinary action was not taken or proposed, providing a detailed justification why such an action was not taken or proposed within 60 calendar days of OAWP's recommendation.

#### **IV. IMPROVING COMMUNICATIONS AND CUSTOMER SERVICE**

OAWP has mandated, through VA Directive 0500, that staff regularly communicate with individuals about the status of their cases. OAWP is collaborating with VA's Veterans Experience Office (VEO) to provide customer service training to all OAWP staff. OAWP is working with VEO to develop a customer survey to measure the impact of these customer service improvements. Customer service, which is a priority for the Secretary and me, will also be a critical element in all performance standards for OAWP employees.

#### **V. OAWP'S WHISTLEBLOWER MENTOR AND OUTREACH PROGRAMS**

In 2017, OAWP established the whistleblower mentorship program, formerly known as the whistleblower reintegration program. After receiving several complaints from VA employees and whistleblowers about the program, I asked that it be placed on hold while we evaluated whether there was appropriate governance and how applicants were identified and interviewed.

After evaluating the program, I identified several deficiencies, including how applicants were identified and interviewed. In light of those deficiencies, the OIG's findings, and because the program was operating outside of OAWP's authorized scope, I have decided to discontinue the program. Instead, OAWP is assessing whether an alternative dispute resolution (ADR) program, similar to OSC, should be established with VA's existing ADR resources.

Prior to my appointment, OAWP also established a whistleblower outreach program. The program was meant to provide whistleblowers with information about

wellness and other resources. However, in view of OIG's findings about the whistleblower mentorship program, we have decided to discontinue the program. Instead, whistleblowers will be informed about services available to them through VA's employee assistance program should they need assistance.

**VI. WHISTLEBLOWER RIGHTS AND PROTECTION TRAINING**

Under 38 U.S.C. § 733, VA is required to implement training for all employees on whistleblower rights and protection. OAWP worked with OSC and OIG to develop training required under 38 U.S.C. § 733. This training will address, among other things, methods for making a whistleblower disclosure, prohibitions against taking an action against an employee for making a lawful disclosure, and penalties for whistleblower retaliation.

The training is being finalized and VA anticipates issuance of the 38 U.S.C. § 733 training, including a specialized module for supervisors through VA's Talent Management System, before the end of the calendar year.

**VII. IMPLEMENTING OAWP'S OTHER FUNCTIONS, REQUIRED BY THE ACT**

As I address the deficiencies within OAWP, I am implementing its statutory function of tracking and confirming VA's implementation of recommendations from audits and investigations carried out by OIG, OMI, OSC, and GAO. As required by law, I am also implementing a process to identify trends based on data received by the office so that VA can proactively address systemic issues.

OAWP is establishing a new VA compliance and oversight team to track and confirm the implementation of recommendations from audits and investigations. The target date for staffing the team and finalizing a directive on these requirements is the end of the calendar year. OAWP also began utilizing an information system in June 2019, to help us identify trends based on the data received by the office.

**VIII. CONCLUSION**

I understand the sense of urgency to improve OAWP operations. I also recognize the substantial impact that the deficiencies in OAWP have had on whistleblowers and VA employees who disclose wrongdoing.

I have the support of the Secretary and VA leadership as I continue to work on fixing those deficiencies. I ask for your support and I appreciate the input from you and your staff as I continue to ensure that OAWP fulfills its statutory mandate.

Mr. Chairman, Ranking Member Bergman, and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today to discuss VA's implementation of the Accountability and Whistleblower Protection Act. I would be happy to respond to any questions you may have.