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The Special Counsel

October 13, 2016

The President
The White House
Washington, D.C. 20500

Re: OSC File Nos. DI-15-2365, DI-15-2840, and DI-15-3117

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding a Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Department of Veterans Affairs (VA), Veterans Benefits Administration (VBA), Oakland VA Regional Office (VARO), Oakland, California. I have reviewed the report and, in accordance with 5 U.S.C. §1213(e), provide the following summary of the agency report, whistleblower comments, and my findings.[1] The whistleblowers, Rustyann Brown, a former claims assistant, Roselyn Tolliver, a veterans service representative, and Lydia Cheney, a veterans service representative, who consented to the release of their names, disclosed that employees at the Oakland VARO failed to properly process a large number of informal requests for benefits and formal benefit applications, dating back to the mid-1990s.

The whistleblowers' allegations were referred to Secretary Robert McDonald for investigation pursuant to 5 U.S.C. § 1213(c) and (d). On January 8, 2016, the VA Office of Inspector General (OIG) publically released a report addressing these matters. On February 1, 2016, the VA informed the Office of Special Counsel (OSC) that this report constituted an official response to the referral. OSC determined that the report did not meet the requirements of 5 U.S.C §1213 (d), and on February 17, 2016, requested a letter containing the signature of an official delegated with the authority to sign the document,

[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).

incorporating the OIG report, and detailing whether any violations of law, rule, or regulation occurred, and if so, whether VARO took any disciplinary action as a result. Then-Interim Chief of Staff Robert D. Snyder was delegated the authority to review and sign this document, which was submitted to OSC on February 29, 2016. The whistleblowers provided comments on April 13 and 25, and May 3, 2016.

The report stated that investigators did not find evidence of a backlog of 13,148 informal VBA claims. However, the report noted that a previous VA OIG investigation had substantiated similar allegations, and confirmed that VARO staff had not processed a "substantial amount" of claims dating back to the mid-1990s. *See* Report No. 14-03981-119, February 18, 2015. Both investigations noted that because of VARO management's poor recordkeeping, the investigations could not verify the existence or location of documents indicating the specific number of unprocessed claims, such as a log or spreadsheet. Nor could the investigations locate a significant concentration of these files in storage cabinets.

In addition, the report noted that VARO managers did not provide the oversight necessary to ensure timely and accurate processing of informal VBA claims, and, as a result, veterans did not receive accurate or timely benefit payments. The report noted that VARO employees did not timely process fifteen percent of files selected for an OIG audit. Of the 60 files selected for the audit, nine featured significant delays in processing, ranging from five to seven years. While the nine affected veterans did receive retroactive payments, they waited on average six and a half years for benefits. In the case with the most significant delay, VARO received an application in February 2006 from a veteran with PTSD and did not correctly process it for seven years and eight months. Additional information provided by the VA noted that the total amount owed to these applicants was over $76,000. In addition to processing delays, the investigation found that VARO staff incorrectly processed ten percent of sampled claims. As a result, five veterans received 25 improper monthly payments totaling approximately $26,325.

The report attributed these deficiencies to inadequate training and noted that VARO management did not provide the oversight needed to ensure timely and accurate processing of informal claims. The report explained that VARO completed the recommended training by December 2015 and finished quality control reviews in May 2016. The agency also reviewed a group of 1,222 backlogged cases identified by the VA OIG in August 2016, determined that 13 percent of them were inaccurately processed, took action to correct these errors, and provided additional training to staff to ensure that errors do not happen in the future. The agency further asserted that the lack of management supervision was a performance concern, but noted that the OIG found no evidence of malfeasance or intent to cause harm. For these reasons, VARO did not take disciplinary action, despite the serious quality control issues that persisted over several years. Additional information provided by the VA indicated that the managers responsible for the initial improper storage were not at VARO during the time of the most

recent reviews. However, this information also noted that VARO Director Julianna M. Boor was appointed in May 2014, and Assistant Director Michele M. Kwok was appointed in April 2012. As such, these two individuals managed VARO during the most recent OIG investigations.

Ms. Brown and Ms. Cheney both stated that they personally processed the files at issue in 2012 and 2015, which the VA OIG reported they were unable to locate. Ms. Brown and Ms. Cheney asserted that they were members of a five-person team assembled in November 2012 to process these claims. Ms. Brown and Ms. Cheney also noted that again in 2015, they were instructed to review large batches of claims, many of which were the same unprocessed files they reviewed in 2012. Furthermore, Ms. Brown asserted that VARO managers consciously hid claim files from investigators in an effort to conceal significant processing delays. She also explained that recommending training was inappropriate, and was a disservice to VARO employees who had attempted to process pending claims but were prevented from doing so by VARO managers who reassigned them to other administrative duties. Ms. Cheney noted similar concerns, asserting that training was not the root cause of the processing delays. Ms. Brown and Ms. Tolliver questioned why VARO did not take disciplinary action against managers responsible for these issues.

I have reviewed the original disclosures, the agency report, and the whistleblower comments. There have been positive steps taken to address processing errors. However, a 2015 VA OIG investigation substantiated allegations concerning a significant backlog of benefit applications, while the report in this matter noted that investigators did not find evidence supporting a backlog. These contradictory conclusions, so close in time, suggest that VARO's poor recordkeeping was so serious that it precluded investigators from thoroughly reviewing the allegations.

In addition, the report acknowledged significant delays and deficiencies in file processing. Notably, the average wait time for applications sampled in this investigation was six and a half years. These are serious delays for disabled veterans, their dependents, and survivors. Despite these findings, the investigation did not recommend disciplinary actions for VARO managers. The whistleblower comments were particularly compelling, calling attention to the lack of management accountability, and the fact that unprocessed claims have been a longstanding problem at VARO.

I have determined that while the report meets all statutory requirements, the proposed corrective actions are unreasonable. The systemic nature of the mismanagement, poor recordkeeping, and significant chronic delays in claims processing require substantial corrective action, beyond the suggested training and quality assurance reviews proposed in the report. The VA should expand on the OIG audit of claim files discussed above, in order ensure that pending benefit applications at VARO are received and reviewed in an expeditious and accurate manner.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency reports, and the whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of these documents in our public file which is available at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures