DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

SEP 11 2015

The Honorable Tim Walz
United States House of Representatives
Washington, DC 20515

Dear Congressman Walz:

This is in final response to your August 11, 2015, letter regarding a 2014 OIG Hotline case referral concerning the St. Cloud VA Health Care System (VAHCS) in St. Cloud, Minnesota. In part, you requested a copy of the case referral, which we provided to you on August 14, 2015. As we explained, we made minimal redactions in accordance with exemption (b)(6) of the *Freedom of Information Act*, which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

You also asked that we respond to five questions related to the OIG's information release policies and whistleblower complaints regarding the St. Cloud VAHCS. Enclosed is our response to those questions. As my staff offered to your staff, we are available to meet to discuss any follow-up questions you might have.

Thank you for your interest in veterans and the Department of Veterans Affairs.

Sincerely,

Linda A. Halliday

LINDA A. HALLIDAY
Deputy Inspector General

Enclosure

Office of Inspector General Response to Questions from Congressman Tim Walz Regarding Information Release Policies and Whistleblower Complaints Concerning the St. Cloud, Minnesota, VA Health Care System

1. **In the last few months, the VA OIG has publically released a number of closed reviews of whistleblower complaints. Why was the 2014 St. Cloud VA report not made public? What is the VA OIG's official policy for releasing these reports?**

This question concerns two types of Office of Inspector General (OIG) reports—final reports and administrative closures—as well as external referrals conducted by VA management at the direction of the OIG. When the OIG accepts an allegation for a case, we conduct investigations, audits, reviews, evaluations, and inspections that result in either an OIG final report or, occasionally, an OIG administrative closure. Because the number of allegations we receive far exceeds our capacity, we make external referrals to VA management for the remaining allegations that we do not accept but that appear to warrant some degree of further review. The 140 reports we released earlier this year were OIG administrative closure reports conducted by our Office of Healthcare Inspections, while the 2014 St. Cloud review was an external referral conducted and written by VA management. Below we describe the distinctions among OIG final reports, OIG administrative closure reports, and external referrals as well as our policies for releasing them.

Final Reports. This is the final product resulting when the OIG initiates a planned or mandated oversight project or accepts a case arising from an allegation submitted through our Hotline or a Member of Congress. There are several different types of final reports including administrative investigations, audits, reviews, benefits inspections, healthcare inspections, Combined Assessment Program reviews, and Community Based Outpatient Clinic reviews. OIG staff perform all of the oversight work described in the final report unless there is an infrequent circumstance where we have sought the assistance of a subject matter expert on a particular issue, and in that case we indicate such in the final report.

The OIG's responsibilities both to disseminate and protect information are determined by Federal law. We go to considerable lengths to make the results of our final reports available to the public through our website, http://www.va.gov/oig. In an effort to release our findings and conclusions publicly, all final reports are reviewed by our Release of Information Office, which is a component of the Office of the Counselor to the Inspector General, for a determination as to whether the final report can be published on our website in its entirety or in redacted format when issued. The Office of the Counselor works closely with the OIG Office of Audits and Evaluations, Office of Healthcare Inspections, and Office of Investigations to write final reports in such a way that they can be made public without any or with minimal redactions.

We list the final report's title and a link to the report on our website the same day it is issued provided the information in the final report is not protected under the Privacy

Act or another confidentiality statute, In those limited situations where the final report contains protected information, only the title and a brief summary are posted initially; if we receive requests for the final report under the Freedom of Information Act (FOIA), the final report will become accessible on our public website in either an unredacted or redacted format.

Under some circumstances, we cannot post our final reports or their titles on the internet because Federal laws protect certain information from disclosure. We do not post our criminal investigative reports, which contain sensitive law enforcement information, or our preaward and postaward contract review reports, which contain sensitive proprietary information.

Administrative Closures. In the interest of maximizing the use of our limited resources, once we determine an allegation is unsubstantiated, is the subject of a claim filed under the Federal Tort Claims Act, or has already been adequately addressed by VA prior to our review, we may at times terminate the investigation, audit, review, evaluation, or inspection without a formal report as an "administrative closure." Until recently, the OIG did not publish administrative closures on our public website. However, on March 17, 2015, the OIG released the following statement from the then-Deputy Inspector General Richard J. Griffin outlining our updated policy on publishing Office of Healthcare Inspections administrative closures:

> *"As a result of a review of Office of Inspector General decision-making practices on closing reviews administratively, the Deputy Inspector General instituted a new policy requiring coordination of administrative closures within the Immediate Office of the Inspector General, the Office of the Counselor to the Inspector General, and the Release of Information Office. This process will ensure consistency in decision-making regarding when and how public release of related documents is handled. The Deputy Inspector General also directed a retrospective review of administrative closures by the Office of Healthcare Inspections from fiscal year 2014 to present. Based on this review, we have begun publishing administrative closure reports on the OIG website. Additional reports will be published pursuant to the Freedom of Information Act as we complete the process of reviewing and redacting sensitive information."*

Our current Deputy Inspector General, Linda A. Halliday, plans to continue the current policy.

The existence of these administrative closures has never been a secret. We have identified the total number of administrative closures in each edition of our Semiannual Report to Congress since 2007. When we determine it is appropriate to administratively close a case that originated through the Hotline, we contact the complainant in writing to advise them how to request the results through a FOIA request. When a congressional external referral closes, we determine whether and to what extent we can provide the results to the Member of Congress for release to the constituent in either a redacted or unredacted format. This determination

depends upon the confidentiality statutes that may apply to the content of VA's response and any supporting documentation. For example, in a letter dated March 14, 2013, we notified you that we administratively closed our review of alleged safety issues and poor management at the Rochester VA Clinic in Rochester, Minnesota, that we conducted at your request and provided you with a minimally redacted copy of the results. A copy of this response is enclosed.

External Referrals. External referrals of cases result from allegations submitted through our Hotline or Members of Congress that the OIG does not accept for review. Because we receive far more allegations than we have the resource capacity to review, the OIG must be highly selective in the cases we accept. We must use our professional judgment to accept only the allegations that we believe represent the most serious risks to veterans, beneficiaries, and taxpayers. 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).[1] VA Directive 0701 requires that VA review the allegations and submit a written response to the OIG that contains:

- Evidence of an independent review by an official separate from and at a higher grade than the alleged wrongdoer.
- Specific review of all allegations.
- The findings of each allegation, which are clearly identified as either substantiated or unsubstantiated.
- A description of any corrective action taken or proposed as a result of a substantiated allegation, (e.g., change in procedures, disciplinary or adverse action taken, etc.).
- Supporting documentation for the review, such as copies of pertinent documents, a summary report of the board of investigations, etc.
- Designation of a point of contact for additional information.

We keep the external referral open until we are satisfied with VA's review or open an OIG case to review the matter further. When we close an external referral that originated through the Hotline, we contact the complainant in writing to advise them how to request the results through a FOIA request. When a congressional external referral closes, we determine whether and to what extent we can provide the results to the Member of Congress for release to the constituent in either a redacted or unredacted format. This determination depends upon the confidentiality statutes that may apply to the content of VA's response and any supporting documentation. Any individual may request the results of any case referral pursuant to FOIA, but the OIG does not otherwise make these work products public because they are not OIG reports. For example, in a letter dated May 15, 2012, we notified you that we closed an external referral related to an incident that occurred with a widow's vehicle while on the grounds of the Malcom Randall VA Medical Center in Gainesville, Florida, which we initiated in response to a request from your staff, and provided you with a minimally redacted copy of the VA's response. A copy of this response is enclosed.

[1] http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=436&FTy. Accessed August 26, 2015.

At this time, we have one external referral in progress in response to your July 17, 2015, letter on behalf of a constituent with concerns about the Intensive Outpatient Treatment Program for Chemical Dependency at the Minneapolis VA Health Care System (VAHCS) in Minneapolis, MN, and a specific veteran who received care from that program. Once we receive and review the VA Midwest Health Care Network Director's response, who has oversight responsibility of the Minneapolis VAHCS, we will determine whether relevant privacy and confidentiality statutes allow us to release the results to you in a redacted or unredacted format.

The 2014 St. Cloud review you requested in your August 11, 2015, letter is an external referral concerning staffing and management issues at the St. Cloud VA Health Care System (VAHCS) in St. Cloud, Minnesota. It was prepared and signed by the then Acting Director, Veterans Integrated Service Network (VISN) 23 Primary and Specialty Medicine Service Line, based on a review conducted by a team from the VISN 23 Network, which excluded any officials from the St. Cloud facility, in accordance with VA Directive 0701. It describes the methodology for the review, the findings for each allegation, and corrective action plans for substantiated allegations. Because the responsibility to correct identified deficiencies rests with VA, not the OIG, and barring the receipt of any new allegations that would warrant additional review, we see no reason for the OIG to review this matter further at this time.

The existence of external referrals is not a secret nor is it a process unique to the VA OIG. For years, our public website has outlined what happens to allegations received by the OIG Hotline,[2] explained how external referrals are processed and resolved,[3] and highlighted statistical information and examples of allegations that were substantiated as a result of these reviews.[4] Other OIGs, including those for the Department of Defense,[5] Department of Health and Human Services,[6] Department of Homeland Security,[7] Department of Housing and Urban Development,[8] Department of Justice,[9] Environmental Protection Agency,[10] and General Services Administration[11] discuss their respective referral processes on their public websites.

2. How does a member of the public have a copy of the report if that report has not been made public? Was it leaked?

It was not leaked. Pursuant to the case referral process described in response to Question 1, the OIG Hotline notified the complainant in an email dated February 9,

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[2] http://www.va.gov/oig/hotline/faq.asp#received. Accessed August 26, 2015.
[3] http://www.va.gov/oig/hotline/faq.asp#processed. Accessed August 26, 2015.
[4] http://www.va.gov/oig/hotline/results.asp. Accessed August 26, 2015.
[5] http://www.dodig.mil/hotline/hotlinecomplaint.html. Accessed August 26, 2015.
[6] https://forms.oig.hhs.gov/hotlineoperations/faqsen.aspx. Accessed August 26, 2015.
[7] https://www.oig.dhs.gov/hotline/hotline.php. Accessed August 26, 2015.
[8] https://www.hudoig.gov/report-fraud. Accessed August 26, 2015.
[9] https://oig.justice.gov/hotline/contact-civil.htm. Accessed August 26, 2015.
[10] http://www.epa.gov/oig/hotline.html#About_Hotline. Accessed August 26, 2015.
[11] https://www.gsaig.gov/GSAOIG-MASTER/assets/File/OIG_Hotline_Presentation-_2014_edited.pdf. Accessed August 26, 2015.

2014, that we closed the case referral and provided instructions on how to request the results through a FOIA request. The complainant submitted a FOIA request, and we provided a redacted copy on March 18, 2014. We redacted information in accordance with FOIA exemption (b)(6), which authorizes the withholding of information that, if disclosed, would invade another individual's personal privacy.

3. **In the last five years, how many complaints have you received regarding whistleblower retaliation and suppression at the St. Cloud VA?**

   In the 5-year period spanning August 17, 2010–August 17, 2015, the OIG Hotline received a total of 123 contacts related to the St. Cloud VAHCS. Of those contacts, four were related to employer harassment or whistleblower retaliation; however, two of the four contacts were from the same complainant regarding the same issue. Therefore, during the 5-year period of August 17, 2010–August 17, 2015, the OIG Hotline received three unique contacts—one each during fiscal years 2013, 2014, and 2015—related to employer harassment or whistleblower retaliation.

4. **Based on the complaints you have received, do you believe there is a pattern of whistleblower suppression in these allegations?**

   We do not believe that these three complaints demonstrate a pattern of whistleblower suppression at the St. Cloud VAHCS. However, as you will read in response to Question 5, the OIG does not generally accept complaints on whistleblower reprisal.

5. **Are there currently any other VA OIG open investigations regarding retaliation and suppression at the St. Cloud VA?**

   No. Because of our limited resources, the OIG does not accept complaints on personnel matters, such as employer harassment or whistleblower reprisal, that can be addressed in other legal or administrative forums. Individuals who contact the OIG Hotline regarding these matters, including the three individuals who raised such issues about the St. Cloud VAHCS, are advised to contact the VA Office of Resolution Management (ORM) and the U.S. Office of Special Counsel (OSC) for further assistance. ORM is the organization within the Department of Veterans Affairs with responsibility for providing alternative dispute resolution services for all workplace disputes, including alleged equal employment opportunity (EEO) discrimination. In cases where resolution cannot be reached informally, ORM processes complaints of EEO discrimination to the U.S. Equal Employment Opportunity Commission.