



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

The Honorable Michael Missal
Inspector General
U. S. Department of Veterans Affairs

Dear Mr. Missal:

I am in receipt of your June 5, 2018 letter addressed to me as the Acting Secretary of Veterans Affairs. I surmise your letter is sent pursuant to section 6(b)(2) of the IG Act because you believe a component of VA has unreasonably refused or not provided requested information. You allege in your letter that the Office of Accountability and Whistleblower Protection (OAWP) has failed "to provide information that has been requested in multiple in-person meetings with [me] and others at VA over the last six months." You also stated in your letter that "repeated assurances" were given that OIG would be granted access to complaints filed with OAWP.

OAWP, a component of the Department of Veterans Affairs like OIG, has found no specific requests for information from OIG that have been denied. Your broad request that appears to seek unrestricted and continuous access to OAWP case intake and triage is neither "practicable" nor appropriate. Your assertion that "it does not appear that an appropriate number of complaints have been referred to the OIG" infers some ill intent by OAWP that contradicts the continuous interaction between OAWP and OIG staff. The lack of cooperation from the OIG Hotline staff and leadership to protect VA Whistleblowers and resolve complaints and disclosures across the VA is promoting the flawed culture the VA Accountability and Whistleblower Protection Act was meant to address. Furthermore, absent a specific request for information, OAWP is unable to determine whether the information you seek relates to the programs and operations with respect to which the IG has responsibilities under the IG Act.

Ironically, your letter does not address the data that should be provided to OAWP by OIG consistent with the VA Accountability Act. Specifically, OIG is mandated to provide OAWP with timely data from telephone hotlines, other whistleblower disclosures, and audits and investigations relevant to fulfilling OAWP's mandated requirement to analyze such data to identify trends and issue reports to me and the Congress based on such analysis and conclusions. OAWP is also required by law to record, track, review and confirm implementation of OIG audits and investigations and cannot do so without information and cooperation from your office.

Recently discovered OIG unrestricted and continuous access to GCLaws (Office of General Counsel restricted document and legal advice system of records) is an unacceptable example of OIG improper overreaching and abuse of authority. Fortunately, upon discovery by

OGC, you and our General Counsel were able to immediately remediate and take corrective action regarding this breach of duties and potential damage to VA's important attorney-client privilege protections.

I am also troubled by OIG not performing its responsibilities in a fair and objective manner which has caused significant harm to the reputation and performance of VA and its employees. The Inspector General Reform Act of 2008 (IG Reform Act) provides that members of the Council of the Inspectors General on Integrity and Efficiency (CIGIE) "shall adhere to professional standards developed by the Council" (§ 11(c)(2) of the IG Reform Act). Specifically, due professional care must be used in conducting investigations and in preparing related reports. Unfortunately, the VA OIG has significantly deviated from this standard in ways that have materially harmed the VA and its employees.

OIG has repeatedly failed to demonstrate due professional care "in conducting investigations and in preparing related reports." Council of the Inspectors General on Integrity and Efficiency (CIGIE) Quality Standards for Investigations. Among the requirements adopted by CIGIE for this standard the VA OIG has failed to adhere to include: thoroughness, legal requirements, appropriate techniques, impartiality, objectivity, timeliness, and, accurate and complete documentation. There are several disturbing examples of OIG investigative reports that improperly and recklessly cast the VA and its employees in an unfavorable light and demonstrate clear investigative misconduct and neglectful senior executive oversight. Examples include reports where the underlying evidence or lack thereof does not support the report's conclusions; evidence is gathered through highly improper, highly suggestive, and highly unreliable techniques; and, pursuing possible exculpatory evidence is ignored or exculpatory evidence that contradicts your chosen narrative is intentionally excluded.

You also appear to misunderstand the independent nature of your role and operate as a completely unfettered autonomous agency. You are reminded that OIG is loosely tethered to VA and in your specific case as the VA Inspector General, I am your immediate supervisor. You are directed to act accordingly.

Sincerely,



Peter O'Rourke