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United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

February 29, 2016

Ms. Linda A. Halliday
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Deputy Inspector General Halliday:

On February 24, 2016, *USA Today* reported that the Department of Veterans Affairs (VA) Office of Inspector General (OIG) has failed to release the results of 77 investigations into potential scheduling manipulation and excessive wait times at 73 VA facilities.[1] I am disappointed that the VA OIG has not improved its transparency in the wake of the Committee's investigation of the VA Medical Center in Tomah, Wisconsin (Tomah VAMC). It is even more troubling that the VA OIG is not disclosing to the public results of its investigations into the biggest scandal in the history of the VA—the manipulation of veterans' appointments and excessive wait times at VA facilities across the country. I write to request the immediate publication of these reports and that the OIG improve its overall commitment to transparency and accountability.

Section 8M of the Inspector General Act of 1978 mandates that inspectors general post audits or reports on their websites "not later than 3 days after any report or audit (or portion of any report or audit) is made publicly available."[2]

Yet over the past year, as the Committee has examined the tragedies of the Tomah VAMC, we have discovered that the VA OIG has an alarming lack of transparency with respect to publishing its reports. On March 17, 2015, I wrote to your predecessor, Deputy Inspector General Richard Griffin, requesting the production of 140 previously-unreleased health care inspection reports dating back to 2006.[3] Six of those previously-undisclosed reports "contain[ed] substantiated allegations, including two involving veterans who were harmed or died."[4] Due to

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[1] Donovan Slack, *VA watchdog sits on wait-time investigation reports for months*, USA Today, Feb. 24, 2016, http://www.usatoday.com/story/news/politics/2016/02/24/va-inspector-general-wait-time-investigation-results/80632212.

[2] 5 U.S.C. App. § 8M(b)(1).

[3] Letter from Ron Johnson, Chairman S. Comm. on Homeland Security & Governmental Affairs to Richard Griffin, Deputy Inspector Gen., Dep't of Veterans Affairs Office of Inspector Gen., Mar. 17, 2015.

[4] Donovan Slack, *VA watchdog stands by decision not to release report*, USA TODAY (Mar. 19, 2015), *available at* http://www.usatoday.com/story/life/2015/03/19/va-watchdog-stands-by-decision-not-to-release-report/25048581/.

our committee's oversight, the VA OIG eventually published all 140 previously unreleased health care inspections on its website.

After seeing the tragic consequences when inspector general work is kept from the public, I spearheaded legislative efforts to make more explicit the need for all inspectors general, including the VA OIG, to publish their reports. On March 4, 2015, the Committee unanimously approved S. 579, the Inspector General Empowerment Act of 2015. The reported bill includes an amendment I proposed to require all inspectors general to publish on their websites any report or audit within three days of the reports' submission "in final form to the head of the federal agency or the head of the designated federal entity as applicable."[5] Senator Tammy Baldwin cosponsored this amendment, and it was unanimously adopted. I offered a similar amendment to the National Defense Authorization Act of 2015, and advocated for a version of the amendment – that would apply just to the VA OIG – to be included in the Military Construction Department of Veterans Affairs Appropriations Bill of 2015.

Demonstrating Congress's strong belief that the VA OIG needs to be more transparent, the Consolidated Appropriations Act of 2016 did include a provision requiring that whenever the VA OIG "issues a work product that makes a recommendation or otherwise suggests corrective action," it must post the work product on the VA OIG's website within three days.[6] This provision is, of course, the bare minimum of what the law requires. Although the VA OIG may not have made "recommendations" or "suggest[ed] corrective action" in its wait times investigations, there is no provision of law prohibiting the VA OIG from posting reports on its website with appropriate redactions to protect patient-sensitive and privacy information. On the contrary, Section 8M of the Inspector General Act of 1978 requires it. With the VA OIG's past failures at transparency, and the numerous calls for greater accountability, I urge you to reconsider your narrow interpretation of the Consolidated Appropriations Act.

It appears that the VA OIG will continue to use every legal technicality and trick available to it to avoid full transparency in its investigations of VA wrongdoing. Given your position, I will continue to push for the inclusion of statutory language that expressly mandates the publication of all VA OIG work product within three days of completion. In the interim, I respectfully request that the VA OIG immediately begin publication of the findings of its schedule manipulation investigations on its website. The health of our nation's veterans—and all those who utilize VA facilities—deserves no less.

If you have any questions about this request, please contact Kyle Brosnan or Brian Downey of the Committee staff at (202) 224-4751. Thank you for your prompt attention to this matter.

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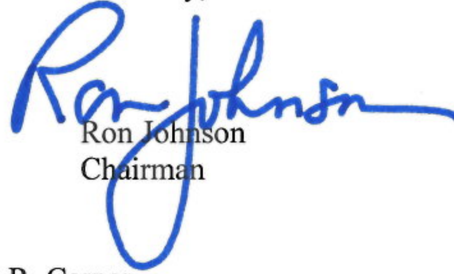
[5] *Id.*

[6] Consolidated Appropriations Act, 2016, Pub. L. 114-113 § 239.

Sincerely,



Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member