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Senior VA Officials'
Response to a Veteran's
Sexual Assault Allegations

ADMINISTRATIVE
INVESTIGATION

REPORT #20-01766-36

DECEMBER 10, 2020



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Executive Summary

On Friday, September 20, 2019, a woman veteran (the veteran or complainant) reported that she was sexually assaulted in the atrium of the Washington DC VA Medical Center while waiting for her medical appointment.¹ The veteran detailed in a statement to VA police that a man, later identified as a service provider under VA contract (the contractor) who routinely works in the medical center, “bumped his entire body against mine and told me I looked like I needed a smile and a good time.” In response to the veteran’s complaint, VA police immediately initiated an investigation and began gathering evidence.

The veteran who made the complaint was, and continues to serve as, a staff member on the U.S. House of Representatives Committee on Veterans’ Affairs (HVAC). She works on issues affecting women veterans for the committee, including efforts to reduce the incidence of sexual harassment and assaults in VA medical centers. On the same day the complaint was filed, HVAC Chairman Mark Takano wrote a letter to Secretary of Veterans Affairs Robert Wilkie with a copy to Inspector General Michael Missal requesting an investigation.² The following business day, Secretary Wilkie wrote to Inspector General Missal and asked the Office of Inspector General (OIG) to investigate.³ Mr. Missal acknowledged that he had received Chairman Takano’s letter and that the OIG had already initiated a criminal investigation. He also noted that the OIG would be working with the U.S. Attorney’s Office for the District of Columbia (USAO).

The Closure of the Criminal Investigation

After a thorough examination of the facts, the joint OIG-USAO investigation was closed in January 2020 with no charges filed against the contractor. Inspector General Missal advised senior VA leaders of this decision at the time and that they should not say anything about the merits of the case based on a decision not to prosecute.⁴ Despite Inspector General Missal’s caution to VA senior staff not to make statements beyond saying the criminal investigation was closed without charges filed, Secretary Wilkie stated in a letter to Chairman Takano on January 15, 2020, “We believe that VA is a safe place for all Veterans to enter and receive care and services, but the unsubstantiated claims raised by you and your staff could deter our Veterans from seeking the care they need and deserve.”⁵ The VA press secretary publicized the

¹ Although the veteran’s name has been made public, it is the policy of the Office of Inspector General (OIG) not to publish the names of complainants alleging sexual assault.

² Letter from HVAC Chairman Mark Takano to VA Secretary Robert Wilkie, September 20, 2019.

³ On Monday, September 23, 2019, Secretary Wilkie emailed a request to the OIG: “I am asking that you investigate this very serious matter and make it an immediate priority for your team.” The OIG subsequently took charge of the investigation, and VA police transferred the evidence and provided support when needed.

⁴ U.S. Dept. of Justice, Justice Manual §§ 9-27.001-9-27.230 (2020).

⁵ Letter from VA Secretary Robert Wilkie to HVAC Chairman Mark Takano, January 15, 2020.

letter to at least nine media outlets and highlighted the content that characterized the allegations as unsubstantiated in an email.

Inspector General Missal responded by letter to Secretary Wilkie emphasizing that no one should be discouraged from reporting an alleged crime and that

Neither I nor my staff told you or anyone else at the Department that the allegations were unsubstantiated. Indeed, in my conversations with [the deputy secretary and chief of staff] on January 14, I specifically told them that the investigation had been closed without charges and that no other characterization could or should be made Reaching a decision to close the investigation with no criminal charges does not mean the underlying allegation is unsubstantiated.⁶

A few weeks later, in response to inquiries from multiple reporters, VA provided statements advising that “Secretary Wilkie acknowledges that describing the allegations as ‘unsubstantiated’ was a poor choice of words, and he withdraws that word.”

The Administrative Investigation

On February 7, 2020, the OIG received a letter from Chairman Takano seeking an investigation into media reports that “VA officials used government time and resources to undermine the credibility of [the veteran] after [Chairman Takano] requested an investigation of her sexual assault allegations at the Washington D.C. VA Medical Center.”⁷ In response, the OIG promptly interviewed multiple VA employees, two of whom confirmed that Secretary Wilkie made nonspecific statements during the joint OIG-USAO criminal investigation suggesting that the veteran who filed the complaint had made similar claims previously.

On February 19, 2020, Inspector General Missal informed Secretary Wilkie that the OIG had received credible information from multiple sources that warranted opening a review into the allegations of VA officials’ misconduct. On February 24, 2020, Senators Richard Blumenthal, Sherrod Brown, Tammy Duckworth, Mazie Hirono, Patty Murray, and Bernard Sanders also wrote to the inspector general seeking an investigation that included a broader examination of

⁶ Letter from Inspector General Michael Missal to VA Secretary Robert Wilkie, January 15, 2020.

⁷ Letter from HVAC Chairman Mark Takano to Inspector General Michael Missal, February 7, 2020. That same day, *ProPublica* reported that “Secretary of Veterans Affairs Robert Wilkie personally sought damaging information about a congressional aide who said she was sexually assaulted in a VA hospital, according to an anonymous complaint to the House committee the woman works for.” Isaac Arnsdorf, “VA Secretary Looked for Dirt on a House Staffer Who Reported Sexual Assault in a VA Hospital, Complaint Says,” *ProPublica*, February 7, 2020. Additional media reports in the following days cited three to four sources who said VA leaders were looking into the complainant’s past to discredit her, actions categorically denied by the Secretary and several senior officials. Lisa Rein, “VA Chief Wilkie Sought to Dig Up Dirt on Woman Who Complained of Sexual Assault, Agency Insiders Say,” *Washington Post*, February 9, 2020; Jennifer Steinhauer, “Veterans Affairs, a Trump Signature Issue, Is Facing Turmoil Again,” *New York Times*, February 13, 2020.

VA's response to the reported incident.⁸ In March, the OIG paused its interviews with senior officials to ensure the officials were not distracted from responding to the COVID-19 pandemic and resumed interviews in August 2020. Details of the OIG's scope and methodology appear in appendix A.

The OIG's investigation was hindered by the refusal of several senior VA officials to cooperate with requests for follow-up interviews to clarify and resolve conflicts that arose when additional information was gathered after their initial interviews. The individuals refusing to cooperate included Secretary Wilkie, Chief of Staff Performing the Delegable Duties of the Deputy Secretary Pamela Powers, Assistant Secretary for Public and Intergovernmental Affairs James Hutton, and Deputy Assistant Secretary for Public Affairs Curtis Cashour. These refusals were made despite the OIG's commitment to keep follow-up interviews as short as possible and to provide flexible times and locations.⁹ Secretary Wilkie and Ms. Powers asked the OIG to provide written questions so they could consider whether to respond. This approach was not consistent with the OIG's investigative practices.¹⁰

Although authorized by statute and regulation to require VA employees to testify in its investigations, the OIG lacks independent authority to compel Department staff to appear for interviews. It depends on the cooperation of VA officials to hold employees accountable for meeting their obligations to cooperate in an investigation.¹¹ Because Secretary Wilkie and his senior advisors have refused follow-up interviews, the OIG determined that compelling employees' cooperation would be futile because it would require the Secretary to take accountability actions concerning individuals who declined to cooperate in the very matter in which he had stopped cooperating. The OIG determined that the most effective path forward was to conclude its work and issue this report without further delay.

⁸ There were a number of requests from Chairman Takano and the senators that are outside the scope of this report, such as examining the number and frequency of sexual offenses nationally in VA facilities and related VA policies. The OIG will continue to diligently investigate allegations of serious criminal activity and closely monitor facilities' environment of care and safety to inform future oversight work.

⁹ Initial interviews of Secretary Wilkie, Ms. Powers, and Mr. Cashour were under 90 minutes, and no interviewee reported spending any time preparing for the interview.

¹⁰ In addition, Congressman Dan Crenshaw and his staff may also have relevant information. The OIG contacted the congressman and a member of his staff to seek voluntary interviews. However, both Congressman Crenshaw and his staff refused to cooperate with the OIG's request.

¹¹ Standards of conduct regulations require VA employees to furnish testimony in agency investigations. *See* 38 C.F.R. § 0.735-12 ("Employees will furnish information and testify freely and honestly in cases respecting employment and disciplinary matters. Refusal to testify, concealment of material facts, or willfully inaccurate testimony in connection with an investigation or hearing may be ground [sic] for disciplinary action.")

The Findings

OIG investigators interviewed 65 individuals, some more than once. Investigators also conducted extensive reviews of emails, telephone records, and other documentation.¹² Despite the refusal by certain VA employees to cooperate fully, the OIG has sufficient information to make five findings.

1. The OIG Cannot Substantiate that Secretary Wilkie Investigated or Asked Others to Investigate the Veteran

In his sworn OIG testimony, Secretary Wilkie denied investigating the veteran. OIG investigators asked more than 20 VA officials whether they were aware of the Secretary or anyone else attempting to collect information relating to prior complaints raised by the veteran of sexual harassment or similar offenses. None of these individuals were specifically aware of any such effort. Two other witnesses told OIG investigators that they were aware of information that suggested otherwise.

A former VA official told the inspector general that as early as mid-October 2019, Secretary Wilkie told him that the veteran had filed “at least six EEO-type complaints” while serving on active duty, information this former official believed the Secretary may have obtained from contacts in the Department of Defense (DoD). Another witness, who is still a VA employee, testified that three days after the incident was reported, a senior VA official commented in a meeting that Secretary Wilkie or others had obtained information about the veteran from DoD sources. This evidence is insufficient to substantiate the allegation because it was not a firsthand account from the Secretary, and the senior VA official identified by the witness denied making such a statement.

Yet as discussed below, multiple witnesses testified that Secretary Wilkie made comments suggesting that he had received such information, even if not by virtue of an effort to gather it. OIG investigators' analysis of VA information systems and a DoD system to which VA employees have access did not identify any improper attempts to access the veteran's records. This analysis is not conclusive, however, because access logging was not activated for the veteran's VA electronic health record, and military record searches were limited to those accessible by VA personnel directly. Accordingly, the OIG cannot substantiate the allegation that Secretary Wilkie investigated or asked others to investigate the veteran.¹³

¹² For more information on the scope and methodology, see appendix A.

¹³ In an administrative investigation, the OIG *substantiates* allegations when the facts and findings support that the alleged events or actions took place. The OIG *does not substantiate* allegations when the facts show the allegations are unfounded. The OIG *cannot substantiate* allegations when there is no conclusive evidence to either sustain or refute the allegation.

2. Senior VA Officials Questioned the Veteran's Credibility, and VA Police Initially Scrutinized the Veteran

VA officials questioned the complainant's credibility from the start. Within hours of receiving word about the complaint on Friday evening, senior VA officials began communicating about whether the veteran had previously complained about verbal abuse from a VA provider at another facility.¹⁴ The next day, Secretary Wilkie speculated in an email that Chairman Takano was "laying the grounds for a spectacle." Suspicions also centered on the veteran's work on sexual assault issues for Chairman Takano and initial misinformation that there was a lack of eyewitnesses.

Senior officials' involvement created pressure on VA police and focused their attention on the veteran herself. VA police interviewed by OIG investigators characterized an unusual level of engagement by VA senior officials in an ongoing criminal investigation. For example, VA senior officials traveled to the medical center the following Monday to view any available video footage. One VA police officer recalled that a visiting VA official suggested that the veteran may have "made a complaint similar to this before." During the video review meeting, VA police also ran a background check on the veteran and circulated the results—an event multiple VA police officers considered unusual. This occurred two days before a background check was run on the contractor accused of sexual assault by the veteran.

3. Multiple VA Officials Testified that Secretary Wilkie Remarked that the Veteran Had Made, or May Have Made, Prior Similar Complaints

In his sworn OIG testimony, Secretary Wilkie denied investigating the veteran, questioning her credibility, or knowing whether she had made prior complaints. However, eight VA senior personnel told OIG investigators about discussions in Secretary Wilkie's presence that involved the veteran's purported history of filing complaints, whether specific to prior sexual assault allegations or similar issues during her military service. Six of these witnesses in sworn testimony attributed the remarks to Secretary Wilkie himself. The inference was that the complaints were unfounded. The first reported instance of such a comment occurred six days after the veteran reported being sexually assaulted. According to the medical center director, Secretary Wilkie made a surprise visit to the facility, read the veteran's statement about the incident, and commented to the director that the statement was "'similar to other complaints she's made other places,' or words to that effect." The other five witnesses testified that the Secretary made similar remarks during meetings in the Secretary's office, questioning whether the veteran had made similar reports in the past. In addition to the eight individuals with knowledge of such statements being made by Secretary Wilkie or in his presence, three other

¹⁴ The OIG identified no evidence of any such complaint by the veteran.

individuals testified to participating in conversations in which VA officials other than the Secretary made comments indicating a belief that the veteran had made prior complaints.

4. VA Officials Attempted to Focus the National Media on the Veteran's Background and Credibility

Secretary Wilkie's statements questioning the veteran's credibility and motivation were not without effect. VA Deputy Assistant Secretary for Public and Intergovernmental Affairs Curtis Cashour suggested to a journalist, "[Y]ou may want to look into—see—if she's done this sort of thing in the past." Mr. Cashour told OIG investigators that this tip was based on communications he had with Secretary Wilkie in which the Secretary stated that the veteran may have made similar complaints in the past. Mr. Cashour stated that he did this on his own initiative and was not operating under direction from Secretary Wilkie or others.

In addition, the VA press secretary released to nine media outlets Secretary Wilkie's letter to Chairman Takano in which he chided Chairman Takano and his staff for raising "unsubstantiated claims" that "could deter our Veterans from seeking the care they need and deserve."¹⁵ After facing weeks of criticism reflected in various media reports, VA characterized this statement as a "poor choice of words." However, OIG investigators determined that the language was deliberate and consistent with VA senior officials' proposed messaging on the topic as shown by some VA senior officials' emails at the time. The phrasing in the Secretary's statement was used even after a VA senior attorney proposed alternative language designed to avoid "detering women veterans from coming forward" by "overly vilifying" the veteran.

5. VA Leaders Did Not Fully Consider or Take Appropriate Administrative and Other Corrective Actions Despite Having Access to Relevant Information

VA policy unambiguously assigns responsibility for investigating matters of significant interest to "the chief executive of the facility or staff office involved, and with their [superior officers] in VA and its administrations."¹⁶ Following the criminal investigation's closure, Secretary Wilkie expressed the need for the OIG to provide a "full accounting" of the joint OIG-USAO investigative results so he could take any action needed to ensure the safety and well-being of veterans. The OIG does not release law enforcement investigation reports as a matter of course, especially where the investigation involves a sensitive matter such as sexual assault. However, it has been the OIG's standard practice during oversight work to immediately inform VA staff of exigent matters relating to the safety of patients or property, which it did in this case. For example, the inspector general informed VA during the course of the criminal investigation that

¹⁵ Letter from VA Secretary Wilkie to HVAC Chairman Mark Takano, January 15, 2020.

¹⁶ VA Directive 0700, *Administrative Investigations*, March 25, 2002.

a security camera at the facility was not working, and after the criminal investigation was closed, the inspector general informed Secretary Wilkie that the suspect had a criminal record and that his parole officer had been notified of the allegations.¹⁷ Secretary Wilkie's assertion that administrative action could not be taken without a "full accounting" from the OIG has no merit.

In further follow-up with senior leaders after a meeting on January 23, 2020, with Secretary Wilkie, Inspector General Missal wrote to the then deputy secretary,

[A]s we have closed the investigation, there is no limitation on the Department conducting its own investigation to determine if any disciplinary or other action is appropriate. For example, staff and concessionaires can be interviewed about the events at issue. The VA Police at the facility may already have a file open. This should allow the Department to obtain the necessary information to make an informed decision.¹⁸

This communication was forwarded to Secretary Wilkie, but VA took no action. Secretary Wilkie and Ms. Powers testified that they did not want to initiate an inquiry that would risk further criticism that they may be investigating the veteran.

VA officials could have made an informed decision about the need for any further inquiry if the Secretary or others had reviewed VA police reports and the files of the medical center director and associate director. These files included a report that a female VA employee had complained in May 2019 of being repeatedly sexually harassed by the same contractor as well as information about the contractor's criminal history. VA officials did not examine this information, readily available in VA's files.

VA officials were also aware of persistent problems reported by women at the medical center but did not ensure facility leaders were addressing these issues. For example, Acting General Counsel William Hudson Jr. testified that following the conclusion of the OIG-USAO investigation he wanted to investigate "what else we need to do in terms of fixing the gauntlet—having been in that D.C. Center, . . . I saw for myself where you've got the coffee shop there and you have people sitting there and you have women running through and going to the clinic. And I could see for myself that it is very distressful for anyone and especially females to go through

¹⁷ Prior to the criminal case's closure, OIG investigators communicated information about the contractor's criminal history to VA police at the medical center. In addition, the OIG reported to VA officials during the investigation at least one broken camera at the facility, which VA remedied, and a potential problem with an entrance door near the women's clinic.

¹⁸ Also attending this meeting between Inspector General Missal and Secretary Wilkie were then Deputy Secretary Jim Byrne, Chief of Staff Pamela Powers, and Acting General Counsel William Hudson Jr. VA policy specifically contemplates that there will be circumstances such as those present here where an administrative investigation will be necessary because the results of "other investigations being conducted into the same or closely related subject matter" may not be available or adequate "to meet VA's informational needs." VA Handbook 0700, *Administrative Investigations*, July 31, 2002.

that and be gawked and stared at.”¹⁹ OIG investigators also determined that the medical center had not actively participated in VA’s national anti-harassment campaign that was announced in October 2019.²⁰ Then Veterans Health Administration (VHA) Deputy Chief of Staff Jon Jensen said in an email about miscommunication with the facility, “I was also just informed that they didn’t know about or do the Stop harassment now declaration signing or the qualitative walking tour. Of all places DC!”

Conclusion

The evidence is replete with examples of VA senior leaders undertaking defensive actions and engaging in confrontational messaging while failing to recognize the need to take corrective action to address known problems. Secretary Wilkie and other VA officials privately disparaged the veteran, with the Secretary referring to her as “the Takano staffer whose glamor shot was in the New York Times.” The tone set by Secretary Wilkie was at minimum unprofessional and at worst provided the basis for senior officials to put out information to national reporters to question the credibility and background of the veteran who filed the sexual assault complaint.

This report details the statements and conduct of senior VA leaders that appear to undermine VA’s stated goals of providing a safe and welcoming environment for all veterans and to treat complainants of sexual assault with respect. VA leaders failed to make meaningful efforts to determine what corrective measures may be needed in response to the sexual assault complaint, while engaging the media to focus on the complainant. Together with statements made by Secretary Wilkie and other leaders, this approach points to a lack of genuine commitment by senior leaders to address the serious issues raised by the veteran’s complaint. The OIG is not making any formal recommendations for the reasons outlined in each section of the report, but will continue to monitor VA’s progress in addressing proposed actions as to the contractor and any administrative actions VA deems appropriate on other issues identified by the OIG.

¹⁹ Ms. Powers told OIG investigators that women veterans described walking through the medical center as a “gauntlet” of unwelcome interactions, such as “cat calls.” Ms. Powers told OIG investigators that conditions in the medical center have improved and that it is no longer a “gauntlet.” However, she was unable to speak to what improvements had been made.

²⁰ As of September 2020, the medical center had not held the events called for by the national anti-harassment initiative that other medical centers rolled out months before the pandemic. See Stand Up to Stop Harassment Now! campaign, finding 5, p. 43.

In response to this report, Secretary Wilkie provided written comments, which are published in their entirety as appendix B, followed by the OIG's reply.

A handwritten signature in black ink that reads "R. James Mitchell". The signature is written in a cursive style with a large initial "R" and a long, sweeping underline.

R. JAMES MITCHELL, ESQ.
Deputy Assistant Inspector General
for Special Reviews

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Abbreviations

AIB	Administrative Investigation Board
DoD	Department of Defense
HVAC	U.S. House of Representatives Committee on Veterans' Affairs
OCLA	Office of Congressional and Legislative Affairs
OIG	Office of Inspector General
USAO	U.S. Attorney's Office for the District of Columbia
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

This report examines serious allegations stemming from VA's response to a veteran's report that she experienced a sexual assault while at the Washington DC VA Medical Center in September 2019.²¹ VA's actions and statements in the wake of the initial incident, during the subsequent criminal investigation, and at the closure of that investigation were the subject of multiple requests that the VA Office of Inspector General (OIG) investigate VA personnel potentially involved in misconduct. Veterans service organizations, members of Congress, and the media voiced specific concerns about VA's possible mishandling of the incident and that VA senior leaders may have investigated the complainant to undermine her credibility—driving the matter into the national spotlight. The allegations questioned VA's response not only to this particular incident, but to the Department's stated commitment to address harassment and sexual assaults within VA facilities nationwide.²²

Criminal Investigation – September 2019 through January 2020

On Friday, September 20, 2019, a woman veteran (the veteran or complainant) reported in a statement to VA police that a man, later identified as a service provider under VA contract (the contractor) who routinely works in the medical center, “bumped his entire body against mine and told me I looked like I needed a smile and a good time.” The veteran making the complaint was, and continues to serve as, a staff member on the U.S. House of Representatives Committee on Veterans' Affairs (HVAC). Later that same Friday, Secretary of Veterans Affairs Robert Wilkie received a letter from HVAC Chairman Mark Takano referencing the incident involving his employee and charging that “atrium café workers and employees at the Information Desk witnessed the assault. Instead of taking immediate action to intervene or assist her, they interacted with the assailant after the assault and took no action.”²³ The letter further asserted that

²¹ Under applicable D.C. law, a range of offensive sexual contact can be prosecuted as criminal violations of varying degrees. For example, while forcible rape may be prosecuted as felony first degree sexual abuse, a lesser violation of misdemeanor sexual abuse may be levied against an individual who “engages in a sexual act or sexual contact with another person and who should have knowledge or reason to know that the act was committed without that other person's permission.” D.C. Code §§ 22-3002, 22-3006 (2020). Sexual contact “means the touching with any clothed or unclothed body part or any object, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person.” D.C. Code § 22-3001 (2020).

²² On October 23, 2019, VHA leaders kicked off a nationwide campaign called ‘Stand Up to Stop Harassment Now!’ In testimony provided on July 22, 2020, before the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, then Acting Deputy Secretary Pamela Powers described this as “a national campaign to prevent all harassment in VA and this campaign includes increased training for medical and support staff to include our police officers, and to ensure they are aware of inappropriate behavior and have the tools to stop it, report it, and prevent it. That campaign includes the distribution of information for veterans and veteran visitors on how to treat everyone with respect in our facilities.” *Hearing on VA Sexual Harassment Before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs*, 116th Conf. (2020) (testimony of Ms. Powers).

²³ Letter from HVAC Chairman Mark Takano to VA Secretary Robert Wilkie, September 20, 2019.

the information desk staff referred the veteran to the Patient Experience and Advocacy office, but the patient advocate “also failed to act or render any assistance when she reported the assault and made her wait to make her report. The first employee at the Medical Center to act and immediately call the police was the doctor she was scheduled to see”²⁴ The chairman requested a series of actions, including that VA refer the matter to law enforcement for investigation.²⁵ The following business day, Secretary Wilkie referred the matter to the OIG via email, writing, “I am asking that you investigate this very serious matter and make it an immediate priority for your team.”

The OIG investigated the sexual assault allegations in coordination with the U.S. Attorney’s Office for the District of Columbia (USAO). In January 2020, the investigation was closed with no criminal charges filed. Inspector General Michael Missal informed VA leaders of the closure on January 14, 2020, and said that they could only comment that the investigation was closed without charges. However, the following day, the VA Secretary sent a letter to Chairman Takano in which he wrote, “We believe that VA is a safe place for all Veterans to enter and receive care and services, but the unsubstantiated claims raised by you and your staff could deter our Veterans from seeking the care they need and deserve.”²⁶ In response, Inspector General Missal sent a letter to the Secretary the same day emphasizing that no one should be discouraged from reporting an alleged crime. He wrote,

Neither I nor my staff told you or anyone else at the Department that the allegations were unsubstantiated. Indeed, . . . I specifically told [Deputy Secretary James Byrne and Chief of Staff Pamela Powers] that the investigation had been closed without charges and that no other characterization could or should be made Reaching a decision to close the investigation with no criminal charges does not mean that the underlying allegation is unsubstantiated.²⁷

A few weeks later, in response to inquiries from multiple reporters, VA provided statements advising that “Secretary Wilkie acknowledges that describing the allegations as ‘unsubstantiated’ was a poor choice of words, and he withdraws that word.”

The OIG Was Asked to Investigate VA Officials’ Responses to the Veteran’s Sexual Assault Allegations – February 2020

On February 7, 2020, Chairman Takano requested in a letter to Inspector General Missal that the OIG investigate whether Secretary Wilkie and other VA officials used government time and

²⁴ Evidence confirms that VA police were not contacted until the veteran saw her doctor. VA police journal records reflect that the patient advocate did eventually contact VA police to report the incident at 11:15 a.m., but that an officer had already been dispatched to the provider’s office at 11:11 a.m. to assist the veteran.

²⁵ The OIG was also copied on this communication.

²⁶ Letter from VA Secretary Robert Wilkie to HVAC Chairman Mark Takano, January 15, 2020.

²⁷ Letter from Inspector General Michael Missal to VA Secretary Robert Wilkie, January 15, 2020.

resources to undermine the credibility of an HVAC staffer after he requested an investigation of her allegations.²⁸ In addition, Chairman Takano's letter stated that an anonymous whistleblower told members of the HVAC that "Secretary Wilkie allegedly attempted to collect information about [the veteran's] military service and credibility in an attempt to discredit her. This included alleged attempts to obtain information or records on previous sexual harassment and assault claims made by [the veteran]."

Then, on February 24, 2020, the OIG received requests seeking an investigation broader than the one called for by Chairman Takano. The letter from Senators Richard Blumenthal, Sherrod Brown, Tammy Duckworth, Mazie Hirono, Patty Murray, and Bernard Sanders raised multiple allegations largely addressed within the scope of this report.²⁹ They included whether Secretary Wilkie or other VA officials sought to discredit the veteran's allegations of sexual assault by seeking and sharing (including with a member of Congress) damaging information on the veteran, particularly whether "VA officials improperly sought information about the individual's past and mischaracterized the results of your investigation into the assault in order to discredit her." The letter also asked the OIG to look at VA's response at the time of and subsequent to the veteran's initial assault complaint, including corrective actions taken by VA.

Relevant VA Officials

The conduct relevant to the allegations centers around the activities of Secretary Wilkie and a core group of other senior political appointees who oversaw aspects of VA's response to the veteran's sexual assault allegations. As a reference for readers, table 1 identifies those individuals and lists their positions held from September 20, 2019, when the veteran reported being sexually assaulted, through October 27, 2020, the end of the investigative review period.

²⁸ Letter from HVAC Chairman Mark Takano to Inspector General Michael Missal, February 7, 2020.

²⁹ Letter from Sen. Richard Blumenthal et al. to Inspector General Michael Missal, February 24, 2020. There were a number of congressional requests from Chairman Takano and the senators that are outside the scope of this report, such as examining the number and frequency of sexual offenses nationally in VA facilities and related VA policies. The OIG will continue to diligently investigate allegations of serious criminal activity and closely monitor facilities' environment of care and safety to inform future oversight work.

Table 1. VA Officials Central to Allegations³⁰

Individual	Position(s) Held (Starting with Most Recent)
Robert Wilkie	Secretary
Pamela Powers	Chief of Staff Performing the Delegable Duties of Deputy Secretary (since August 31, 2020) Acting Deputy Secretary (April 29 through August 31, 2020) Acting Deputy Secretary and Chief of Staff (from April 2 through April 29, 2020) Chief of Staff (through April 2, 2020)
Brooks Tucker	Assistant Secretary for Congressional and Legislative Affairs Performing the Delegable Duties of Chief of Staff (since August 31, 2020) Acting Chief of Staff (from April 29 to August 31, 2020) Assistant Secretary for Congressional and Legislative Affairs (remained in dual role after designation as acting chief of staff)
James Hutton	Assistant Secretary for Public and Intergovernmental Affairs
Curtis Cashour	Deputy Assistant Secretary for Public Affairs
William Hudson Jr.	Principal Deputy General Counsel Performing the Delegable Duties of the General Counsel (since April 13, 2020) Acting General Counsel (from November 10, 2019, to April 13, 2020) Principal Deputy General Counsel (since November 10, 2019)
James Byrne	Deputy Secretary (through February 3, 2020)

Source: *OIG analysis of positions held from September 20, 2019, through September 1, 2020.*

The Administrative Investigation Timeline and VA Officials' Refusal to Fully Cooperate

On February 19, 2020, Inspector General Missal met with Secretary Wilkie, Chief of Staff Pamela Powers, and Acting General Counsel William Hudson Jr. and notified them that the OIG was initiating a review of the allegations.³¹ However, on March 18, 2020, the OIG indefinitely postponed interviews of senior VA officials because these and other individuals with personal knowledge of the events were also key personnel in charge of managing VA's response to the COVID-19 pandemic. The OIG took several other measures around this time to ensure that its work did not distract VA leaders from addressing the pandemic and its effect on veterans, their families, and the public. Also, in response to the pandemic, Secretary Wilkie suspended his monthly meetings with the inspector general beginning in March 2020. These meetings resumed

³⁰ Multiple individuals have experienced changes to their official titles two or more times since this investigation was initiated. In order to minimize confusion, except where context requires otherwise, this report will use individuals' titles as of February 7, 2020, the date of the congressional request that started this administrative investigation.

³¹ The OIG responded to the members of Congress on February 27, 2020, to confirm that it would conduct a review in response to the requests received.

on July 20, 2020. As VA began reopening facilities and returning to more routine functions, the OIG team resumed scheduling interviews with witnesses. At the July monthly meeting, Secretary Wilkie advised the inspector general that he would like to have this matter “behind him.” The OIG investigative team promptly scheduled interviews with him and other key personnel.

On August 5, 2020, OIG investigators interviewed Secretary Wilkie and Ms. Powers. Thereafter, investigators interviewed 27 other individuals (VA and non-VA) and, by September 25, 2020, the OIG had identified which follow-up interviews were needed to resolve conflicts among witnesses' testimony and to clarify additional information. Investigators promptly reached out to Secretary Wilkie and Ms. Powers indicating that the OIG was concluding its work and seeking to schedule a follow-up interview. The likely need for a follow-up interview had already been explained to each witness at the end of the initial interview. During her interview, Ms. Powers responded to this advisement, “Happy to talk.” The following month she responded to the OIG's request to schedule a follow-up interview through her assistant, who stated, “She does not feel that there is any additional information she can provide and declines to meet for additional meetings on this subject.” Assistant Secretary for Public and Intergovernmental Affairs James Hutton and Deputy Assistant Secretary for Public Affairs Curtis Cashour issued near verbatim responses, in which they stated they “respectfully decline” to be interviewed again.

On September 28, 2020, Inspector General Missal spoke with Mr. Hudson about the investigators' requests for follow-up interviews of Secretary Wilkie and Ms. Powers. Mr. Hudson reaffirmed that neither intended to grant the request. On October 1, 2020, Mr. Hudson wrote to the inspector general at the request of Secretary Wilkie and Ms. Powers and asked the OIG to submit written questions as justification for a second interview and for potentially responding to them in lieu of an interview.³² The OIG determined that written questions were not an appropriate substitute for an investigative interview, and the inspector general explained in an October 5 letter to Mr. Hudson that the OIG has the authority to determine when and how to investigate.³³ The inspector general's letter also corrected mistakes in Mr. Hudson's description of the length of the initial interviews, assumptions about the scope of OIG investigations, and an interviewee's ability to dictate the mode of information-gathering. The letter offered another opportunity to either provide convenient interview dates or confirm that the Secretary and Ms. Powers were declining to cooperate further. In soliciting dates and

³² Letter from Principal Deputy General Counsel, Performing the Delegable Duties of the General Counsel, William Hudson Jr. to Inspector General Michael Missal, October 1, 2020.

³³ Letter from Inspector General Michael Missal to Principal Deputy General Counsel, Performing the Delegable Duties of the General Counsel, William Hudson Jr., October 5, 2020; *U.S. Nuclear Regulatory Commission, Washington, D.C. v. Fed. Labor Relations Auth.*, 25 F.3d 229, 234 (4th Cir. 1994) (holding that procedural conditions pertaining to inspector general investigative interviews are not an appropriate subject for bargaining between the agency and its labor unions). The OIG uses follow-up interviews to clarify prior statements in light of information gleaned after an initial interview, address conflicting testimony, and assess the individual's demeanor during questioning. These interviews advance accuracy and fairness in reports. Subjects of interviews cannot restrict OIG work to less effective and limited options.

times for an interview, the inspector general expressed OIG staff's willingness to be accommodating as to times and locations and to conduct the interview in as short a time as possible.³⁴ Mr. Hudson replied by letter on October 6, 2020, but did not respond to the inspector general's request for dates and did not confirm that Secretary Wilkie and Ms. Powers were declining to cooperate further, but instead reasserted their position that the OIG needed to justify its request.³⁵ The response ignored the justification provided in the inspector general's October 5 letter that

As is routine, follow-up interviews are conducted when there is a need to reconcile apparent inconsistencies in testimony, to seek testimony on information discovered after an initial interview, and to clarify prior testimony. [They] provide interviewees with an important opportunity to explain and confirm the accuracy of their sworn statements OIG investigators have considered the record and determined that it is appropriate to seek additional information . . . , including from the Secretary and [Ms. Powers], and . . . both were alerted during their prior interviews that the record remained open and a follow-up interview may be necessary.³⁶

Inspector General Missal answered in turn on October 7, "Given this is our third attempt to schedule the follow-up interviews, and your letter fails to identify when the Secretary and [Ms. Powers] are available for an interview within the next seven business days, I consider your response a declination on their behalf to cooperate further in the OIG's review in this matter."³⁷ No further response was provided by Mr. Hudson, Secretary Wilkie, or Ms. Powers.

These refusals hindered the OIG's investigation and frustrated the purpose of the Inspector General Act of 1978.³⁸ Although authorized by statute and regulation to require VA employees to testify in its investigations, the OIG lacks independent authority to compel VA staff to appear for interviews. Accordingly, it is dependent on the cooperation of VA officials to hold employees

³⁴ The initial interviews of Secretary Wilkie and Ms. Powers were both under 90 minutes.

³⁵ Letter from Principal Deputy General Counsel, Performing the Delegable Duties of the General Counsel, William Hudson Jr. to Inspector General Michael Missal, October 6, 2020.

³⁶ Letter from Inspector General Michael Missal to Principal Deputy General Counsel, Performing the Delegable Duties of the General Counsel, William Hudson Jr., October 5, 2020.

³⁷ Letter from Inspector General Michael Missal to Principal Deputy General Counsel, Performing the Delegable Duties of the General Counsel, William Hudson Jr., October 7, 2020.

³⁸ Inspector General Act of 1978, Pub. L. No. 95-452, §§ 6(a)(1), 6(a)(5) (1978) (authorizing the Inspector General "to have timely access" to all materials available to VA and "to administer to or take from any person an oath, affirmation, or affidavit, whenever necessary in the performance of the functions assigned by this Act."); Inspector General Act of 1978 § 3(a) ("Neither the head of the establishment nor the officer next in rank below such head shall prevent or prohibit the Inspector General from initiating, carrying out, or completing any audit or investigation . . .").

accountable for their obligations to cooperate in an investigation.³⁹ Here, where Secretary Wilkie and his senior-most advisors have collectively refused to voluntarily cooperate with the OIG's follow-up requests for testimony, the OIG determined that compelling cooperation would be futile because it would require the Secretary to take accountability actions against individuals declining to cooperate in the very matter in which he had stopped cooperating. Moreover, the process would introduce even longer unwarranted delays in concluding the investigation. In this instance, the OIG determined that the most effective path forward was to conclude its work and issue this congressionally requested report without further delay.

³⁹ Standards of conduct regulations require VA employees to furnish testimony in agency investigations. *See* 38 C.F.R. § 0.735-12 (“Employees will furnish information and testify freely and honestly in cases respecting employment and disciplinary matters. Refusal to testify, concealment of material facts, or willfully inaccurate testimony in connection with an investigation or hearing may be ground [sic] for disciplinary action.”)

Findings and Analysis

As the sections below detail, the OIG could not substantiate that Secretary Wilkie investigated the veteran's background or improperly accessed her electronic health and military records (or directed others to do so). There is, however, substantial evidence that Secretary Wilkie made comments that questioned the veteran's credibility or were otherwise denigrating to her, including statements from witnesses who understood that, as of the week of September 23, 2019, Secretary Wilkie had obtained potentially damaging information about the veteran's past. The OIG investigation also revealed that the tone created by the VA Secretary and other officials who questioned the complainant's motives and credibility negatively affected how other VA personnel conducted themselves. At the same time, VA did not undertake an adequate remedial response to the underlying issues raised by the veteran's complaint. In particular, the OIG made these five findings based on sworn testimony and extensive document reviews:

1. The OIG cannot substantiate that Secretary Wilkie investigated or asked other officials to investigate the veteran's background (including accessing available military and VA electronic health records).
2. Senior VA officials almost immediately questioned the veteran's credibility. Senior officials' involvement created pressure on VA police and focused their attention on the complainant, including police conducting a background check on the veteran before the contractor she accused.
3. Although the OIG cannot substantiate that Secretary Wilkie actively investigated the veteran's past or directed others to do so, multiple VA officials testified that the Secretary remarked that the veteran had made, or may have made, prior similar complaints. Senior officials testified that the remarks were stated in a way to imply the prior complaints were unfounded.
4. Secretary Wilkie's statements appeared to set the tone for VA officials' attempts to focus the national media on the veteran's background and credibility, including a senior public affairs official suggesting that a journalist investigate whether the veteran had "done this sort of thing in the past." The VA press secretary also distributed a communication to nine media outlets mischaracterizing the criminal investigation results as "unsubstantiated."
5. VA leaders did not fully consider or take appropriate administrative and other corrective actions at the Washington DC VA Medical Center. This included a failure to review available information about the contractor accused of sexual assault and to continue improving the medical center's environment, which was known to be inhospitable to women.

Finding 1: The OIG Cannot Substantiate that Secretary Wilkie Investigated or Asked Others to Investigate the Veteran

OIG investigators found insufficient evidence to substantiate that Secretary Wilkie investigated or asked anyone else to investigate the veteran's background, military service, or health records. Secretary Wilkie denied undertaking such an effort, and over 20 VA officials testified that they were unaware of his doing so. One witness told OIG investigators that he had personal knowledge suggesting that Secretary Wilkie actively collected information about the veteran. A second witness testified that during a meeting in September 2019, the witness heard the deputy assistant secretary for congressional and legislative affairs make a comment indicating that a particular individual at the Department of Defense (DoD) had provided information about the veteran to VA officials. For the reasons discussed below, neither of the witness accounts could be corroborated.

OIG investigators' analysis of VA information systems did not identify any improper attempts to access the veteran's records. As discussed in this section, the analysis is not conclusive because access logging was not activated for the veteran's VA electronic health record. However, a review of data from those systems that did have access logs did not reveal unauthorized or improper record retrievals. With respect to the veteran's military records, OIG investigators confirmed that no access attempts had been logged with respect to the veteran's personnel records that are available to VA employees. This is also not dispositive because DoD record systems are decentralized, and there are repositories of information not in the VA-accessible system (subject to OIG oversight) that may be accessed or conveyed by DoD personnel.

Accordingly, the OIG cannot substantiate the allegation that Secretary Wilkie investigated or asked others to investigate the veteran.⁴⁰ The investigative team did find, however, substantial evidence that Secretary Wilkie questioned the credibility of the veteran and purported that she had made prior similar complaints.⁴¹

⁴⁰ In an administrative investigation, the OIG *substantiates* allegations when the facts and findings support that the alleged events or actions took place. The OIG *does not substantiate* allegations when the facts show the allegations are unfounded. The OIG *cannot substantiate* allegations when there is no conclusive evidence to either sustain or refute the allegation.

⁴¹ See finding 3. Also, as discussed in finding 4, the Secretary's statements set a tone that led VA officials to make statements designed to discredit her in the national media.

The OIG Did Not Corroborate Two Witness Statements Indicating that Secretary Wilkie Actively Sought Information about the Veteran

When asked by OIG investigators whether he attempted “to collect information about [the veteran’s] military service, her credibility or any matter relating to her past,” Secretary Wilkie testified, “No. Absolutely not.” OIG investigators asked more than 20 VA officials whether they were aware of the Secretary or anyone else attempting to collect information relating to prior complaints raised by the veteran of sexual harassment or similar offenses. None were aware of any such effort.

Two additional witnesses, however, told OIG investigators that they were aware of information that suggested otherwise. Former Deputy Secretary James Byrne told the OIG that as early as mid-October 2019, Secretary Wilkie told him that the veteran had filed “at least six EEO-type complaints” while serving on active duty.⁴² Mr. Byrne also told the OIG these complaints were lodged when the veteran was not satisfied with her performance evaluations.⁴³ He did not know the source but speculated that Secretary Wilkie had obtained this information by reaching out to contacts within the DoD. He also told the OIG that Secretary Wilkie later verified with Congressman Dan Crenshaw that the veteran had previously filed frivolous complaints when the two were serving in the same command in the Navy.

When interviewed, Secretary Wilkie told OIG investigators that it was Mr. Byrne who told him that “he [Mr. Byrne] had heard” that the veteran’s unit was one where “there were members who, when they did not get a good report would file a sexual [discrimination] complaint.” Secretary Wilkie continued, however, by cautioning OIG investigators when evaluating the reliability of that statement made to him by Mr. Byrne, “[R]emember, this is a town that runs on rumors.”

The OIG was unable to reconcile this direct conflict in the testimony, in part because Mr. Byrne’s interview occurred after Secretary Wilkie’s, and Secretary Wilkie declined the OIG’s request for a follow-up interview. Secretary Wilkie and other senior VA officials

⁴² OIG investigators confirmed in sworn testimony of the veteran that she had made a single complaint while serving on active duty, which is a matter that she has also discussed in public statements. According to her legal counsel, the complaint was substantiated, and disciplinary action was taken with respect to the individual accused of wrongdoing.

⁴³ OIG investigators reviewed the veteran’s personnel file and did not identify any unsatisfactory performance evaluations.

preemptively questioned the veracity of any information that the OIG might receive from Mr. Byrne, ascribing motivations related to his dismissal by the Secretary in February 2020.⁴⁴

OIG investigators reviewed Mr. Byrne's archived records and did not identify any documentary evidence corroborating his statements to the OIG. As shown in figure 1, OIG investigators identified a single communication sent by Mr. Byrne to a VA employee that appears consistent with his statements to OIG investigators. However, the reliability of this communication's content is uncertain because it was sent three days after Secretary Wilkie terminated Mr. Byrne's employment. The recipient of the communication denied having any awareness that Secretary Wilkie or anyone else was conducting any form of investigation into the veteran's past. As discussed in finding 3, however, this employee and others were aware that in multiple small group meetings or discussions, Secretary Wilkie had suggested that he had information about prior allegations of sexual harassment or assault raised by this veteran.



*Figure 1. February 6, 2020, text message to a VA employee from Mr. Byrne.
Source: Message recipient, pursuant to OIG subpoena.*

OIG investigators also received relevant testimony from a second witness suggesting that Secretary Wilkie or other senior officials may have obtained information about the veteran from sources within the DoD, but this testimony was not a first-person account and therefore is not

⁴⁴ On February 3, 2020, Secretary Wilkie issued a statement indicating that he had “dismissed VA Deputy Secretary James Byrne due to loss of confidence in Mr. Byrne’s ability to carry out his duties.” Ms. Powers told OIG investigators, and other witnesses corroborated, that Mr. Byrne was fired from his position because it was believed that Mr. Byrne attempted to plant a media story that VA officials thought could be perceived as discrediting to Ms. Powers and another VA official.

sufficiently reliable to corroborate Mr. Byrne's account.⁴⁵ The witness is a VA employee (the employee) who works in regular contact with senior political appointees. The employee told OIG investigators that on either Monday or Tuesday after the veteran reported being sexually assaulted, the employee attended a meeting also attended by VA Office of Congressional and Legislative Affairs (OCLA) staff. The employee testified that the deputy assistant secretary for congressional and legislative affairs "walked into the room and he had just come from the tenth floor" (a reference to the executive floor and Secretary's office) and commented that the veteran was raising the sexual assault allegations "to push some legislation, because she had some legislation in her purse that was going [to] mandate that all VA had to go through some kind of sexual assault prevention training"

According to the employee's testimony to the OIG, the deputy assistant secretary also stated that the veteran is "a serial complainer. She's filed multiple sexual assault complaints when she was in the Navy." The employee further testified that the deputy assistant secretary referred to senior VA officials, potentially including Secretary Wilkie, and commented "Yeah, they know someone in the Pentagon that can confirm that." The employee provided OIG investigators with handwritten notes and testified to having made the notes during this meeting in September 2019. The notes contain references to several facts relating to VA's initial review of the circumstances surrounding the veteran's complaint. The notes also include the first name of an individual who, according to the VA employee, was identified by the deputy assistant secretary as a DoD employee who provided information about the veteran.

OIG investigators contacted an individual working in a DoD manpower and personnel office (the DoD employee) who the VA employee posited may be the person that was referred to by the deputy assistant secretary. The DoD employee told OIG investigators that no one ever contacted him concerning the veteran and that he did not have the ability to access any information about the veteran.

In his OIG testimony the deputy assistant secretary for congressional and legislative affairs also denied hearing Secretary Wilkie or others comment that they obtained information about the veteran. In addition, the deputy assistant secretary denied having made the statement attributed to him by the employee. Other individuals identified as possibly in attendance could not recall the meeting and did not recall the deputy assistant secretary making the statement described by the employee. Although the employee's contemporaneous notes appear to support that the alleged incident involving the veteran was discussed in some detail at this meeting, the reported

⁴⁵ As detailed in finding 3, the director of the Washington DC VA Medical Center testified that during a visit on September 26, 2019, Secretary Wilkie reviewed the veteran's statement to VA police and commented that it was "'similar to other complaints she's made other places,' or words to that effect." This is a first-person account of a statement made by Secretary Wilkie less than seven days after the incident referencing prior complaints by the veteran. However, the medical center director was unsure whether the Secretary was referencing complaints made while in the military or whether this may have been a reference to complaints about other VA facilities. He was also unaware of whether the information was obtained as the result of any active inquiry by or on behalf of the Secretary.

conversation about the veteran previously filing complaints was not memorialized in the notes. As such, the notes are insufficient documentary evidence to corroborate that Secretary Wilkie or any other senior official sought to obtain information about the veteran from a DoD source. The differences in the testimony of the employee and the deputy assistant secretary are irreconcilable.

Available Logs Did Not Indicate Improper Access to the Veteran's VA Electronic Health Records, but Not All Access Methods Were Logged

OIG investigators reviewed records systems routinely used by VA personnel to determine whether improper access had been made to the veteran's electronic health records or military service records accessible by VA. With respect to the electronic health records, the OIG cannot conclusively determine whether anyone made improper access because the access logging feature of the Computerized Patient Record System (CPRS) interface to VA's electronic health records system was not activated for the veteran's record.⁴⁶ Veterans Health Administration (VHA) policy provides that when a veteran is involved in a high-profile incident, the medical center leadership is responsible for determining whether to flag the veteran's electronic health records as sensitive, which will trigger logging of any subsequent access to the record.⁴⁷ The Washington DC VA Medical Center director told OIG investigators that he was unaware of this procedure and that, had he been aware, he would have requested that the veteran's record be flagged as sensitive. The OIG reviewed access logs for other systems used to access veteran health and benefits records, including the Compensation and Pension Record Interchange (CAPRI), Joint Legacy Viewer (JLV), Share system, and Veterans Benefits Management System (VBMS). The OIG did not identify any improper access to the veteran's records originating from those systems.

In addition to VA-managed systems, authorized VA personnel have access to a DoD system for personnel files called the Defense Personnel Records Information Retrieval System (DPRIS).⁴⁸ OIG investigators determined that there was no evidence of any VA personnel accessing the veteran's personnel record from September 20, 2019 (the day of the complaint), to February 7, 2020 (the date Chairman Takano requested this investigation). The OIG also confirmed that the veteran's military personnel file in DPRIS did not contain information pertinent to any prior complaints she may have filed.

⁴⁶ As discussed in appendix A, multiple interface portals provide authorized VA employees with access to a veteran's electronic health record. For those portals where access logging is available, OIG investigators determined that no improper access occurred.

⁴⁷ VHA Memorandum, "Flagging Health Records for High Profile Incidents (VAIQ #7780142)," May 15, 2017.

⁴⁸ The OIG limited its review to systems accessible by VA employees. OIG investigators lacked sufficient information to make requests for records from any of the other DoD systems and decentralized records. See appendix A, Scope Limitations.

Finding 1 Conclusion

OIG investigators found insufficient evidence to substantiate that Secretary Wilkie investigated or asked anyone else to investigate the veteran's background, military service, or health records. Other than Mr. Byrne, no witnesses testified that they had firsthand knowledge that Secretary Wilkie actively collected or asked anyone else to collect information about the veteran. A second witness provided testimony and notes he claimed to have taken contemporaneously indicating that the deputy assistant secretary for congressional and legislative affairs made remarks in September 2019 suggesting that senior VA officials had received information about the veteran from a DoD source. The deputy assistant secretary denied making the remarks.

Secretary Wilkie and Mr. Byrne provided irreconcilable statements concerning information purportedly received by one or the other about the veteran's past. Secretary Wilkie's refusal to provide investigators with a follow-up interview precludes further examination under oath of this discrepancy. OIG investigators' analyses of VA information systems did not identify any improper attempts to access the veteran's records, but this analysis is not conclusive because access logging was not activated for the veteran's electronic health record. There was no improper access found in DPRIS as to the veteran's military record, and there was insufficient specific information to warrant the type of extensive search of DoD's decentralized records that would have been needed to provide any level of certainty.

Finding 2: Senior VA Officials Questioned the Veteran's Credibility and VA Police Initially Focused on the Veteran

Although the OIG did not find evidence sufficient to substantiate that Secretary Wilkie investigated or asked others to investigate the veteran's background, the OIG found substantial evidence that Secretary Wilkie and other senior VA leaders doubted the veteran's allegations and questioned her motivation almost immediately after learning of her complaint. The skepticism was demonstrated in the Friday, September 20, 2019 evening communications and actions among VA officials shortly after they learned of the veteran's allegations. By Monday, September 23, these doubts were also evident in the work of VA police investigators who began to scrutinize the background of the veteran prior to investigating the alleged assailant's background.

As discussed in findings 3 and 4, this initial skepticism matured into repeated, apparently unsupported assertions or vague conjectures that the veteran did "something like this" before, which similarly contributed to VA personnel actions focusing on the veteran and her credibility.

VA Personnel Ascribed a Political Motive to the Veteran's Complaint due to Her Public Policy Work for Women Veterans

Some witnesses interviewed by OIG investigators explained that the veteran's allegations were met with immediate skepticism when the incident was reported to VA police in September 2019, in part because of the veteran's high-profile occupation serving on the majority staff of the House Committee on Veterans' Affairs (HVAC), chaired by Democratic Congressman Mark Takano. She has worked for the HVAC and has served on the committee's Women Veterans Task Force, which was launched in May 2019 "to promote inclusivity and equitable access to resources, benefits, and healthcare for women veterans." In her role, the veteran is highly visible on issues of importance to women veterans.

Earlier on the same day that she reported being sexually assaulted, the veteran had participated in a bill-drafting session aimed at reducing the incidence of sexual harassment and assaults in VA medical centers, a coincidence which led several senior VA officials to view her allegation suspiciously. VHA Chief of Staff Larry Connell told OIG investigators, "I don't think it's a secret that there was a rub between Chairman Takano and the Secretary at the time that—that this could be a setup to make the Secretary look bad. But I don't remember exactly who said that." He added, "It was more than one." Similarly, the medical center director told OIG investigators about "water cooler talk" that "the timing [of the veteran's allegations] was interesting. This happens as she comes from a session where they had just come up with draft legislation for bystander intervention training."

The veteran's allegations were received at 5:12 p.m. by Mr. Tucker, assistant secretary for congressional and legislative affairs, and within two hours, senior staff from VA headquarters, VHA, Public Affairs, and OCLA were communicating about the incident. Emails among senior

VA officials reflect varying levels of skepticism about the credibility of the veteran's allegations as the officials awaited additional information:

- At 6:55 p.m., Acting Principal Deputy Under Secretary for Health Dr. Steven Lieberman wrote to Mr. Connell, VHA Executive in Charge Dr. Richard Stone, and others, "I remember we had a prior complaint from her about another visit [*sic*] facility. At that point I believe she claimed mostly about verbal abuse from a provider."⁴⁹
- At 8:09 p.m., Mr. Byrne sought permission to contact the veteran to "express VA leadership's sympathies and outrage." Secretary Wilkie instructed Mr. Byrne to "stand down until we get the report from Larry Connell and the police."⁵⁰
- At 8:55 p.m., Mr. Connell wrote to Dr. Stone, Dr. Lieberman, and others providing a status update: "Spoke to Assistant Director; Appears the alleged assault did occur." The assailant "reportedly pushed his groin into [the veteran's] buttocks while she was in line (not sure which line). I have asked [the medical center assistant director] to get me a copy of video and Police report by tomorrow."
- At 7:22 a.m. the next morning (Saturday), Secretary Wilkie wrote to Mr. Tucker and Ms. Powers that he believed Chairman Takano and his staff were "laying the grounds for a spectacle."
- Days later, on September 25, 2019, Mr. Tucker emailed an OCLA staff member and characterized a planned press conference by Chairman Takano as "very poor behavior from the HVAC." The OCLA staff member responded, "The sensitivity of this topic . . . makes me not want to be a naysayer but there are way too many coincidences that surround this. Even in the ideal world, the stars would never align like they have in this case."
- The medical center director told OIG investigators that during a call on September 25, 2019, he was admonished by either Mr. Tucker or another central office official, "[Y]ou can't be apologizing for things that we haven't confirmed actually happened," in response to the medical center director's call to the veteran to "express empathy that she had a bad experience."

⁴⁹ Dr. Lieberman told OIG officials that he could not recall what he meant, nor did the recipients of the email who were interviewed by OIG investigators. The OIG did not identify any complaints about any VA providers made by the veteran.

⁵⁰ The next day Mr. Byrne wrote to the HVAC staff director, "Please extend to her my sympathy and assurance that VHA and possibly OIG will thoroughly investigate this matter." According to Mr. Byrne, he was not authorized to make this outreach.

Questions about the Veteran's Allegations Led Senior VHA Officials to Visit the Medical Center

The incident occurred on a Friday. Throughout the weekend, Mr. Connell and other VA officials requested and received information from the medical center. The information being sought included any available video footage as well as the VA police's investigative report, which was not yet written.⁵¹ The extent of VHA senior official involvement was described as unusual in this instance. Although one expects that an incident involving congressional staff might garner more attention, the VHA senior security officer who participated in the meeting told OIG investigators that it was unusual to have this level of engagement for other sexual assault allegations and other congressional requests.

On Monday morning, September 23, 2019, senior VHA officials, including Mr. Connell and Dr. Stone, traveled to the medical center for an hour-long special meeting to review any available video footage and meet as a leadership team to discuss how to respond to the incident.⁵² A VA police officer told OIG investigators that during the meeting Mr. Connell repeated his request for the police report, but that Dr. Stone intervened and told Mr. Connell, "No, we need to allow them to do their job."

In addition, Mr. Connell told OIG investigators that some skepticism was fueled by the lack of eyewitnesses identified by VA police in the first few days after the incident was reported. Mr. Connell explained that the lack of eyewitnesses did not make sense because "on any typical day, there is the better part of a hundred veterans in the [public area where the incident occurred], and they couldn't find a witness to this. So, yeah, [VA officials] started asking questions about [the credibility of the allegations]." Mr. Connell explained that these doubts were a factor in why he was seeking to secure the video footage: "So people started questioning if it really happened, which is kind of why we wanted the video to either confirm or deny [the veteran's] allegations." In fact, VA police investigators identified multiple eyewitnesses within a matter of days. Unconfirmed (and incorrect) details such as these sometimes emerge during the preliminary stages of a criminal investigation but ordinarily would not be known to senior VA officials. In this instance, because senior officials were actively engaged in seeking real-time updates during the early days of the investigation, they had access to this misinformation, and it affected their views regarding the credibility of the complainant.

⁵¹ The only written "reports" that would have existed at this stage included the voluntary statements supplied by the veteran making the complaint and the medical provider who assisted her in contacting the police.

⁵² The special meeting began at 10:30 a.m. Other VHA staff in attendance included Deputy Under Secretary for Health Operations and Management Renee Oshinski, the VHA senior security officer, the medical center director, and the assistant medical center director. They were joined by multiple officers from the VA police department and an OIG criminal investigator.

Senior VHA Officials Risked Interfering with or Introducing Bias to the VA Police Investigation

As mentioned above, according to VA police officers involved in the investigation, the direct involvement of VA's most senior leaders in seeking information on developments as they happened was unusual. As one VA police officer explained, "I just felt like it was pressure. It was a lot of involvement. We set out to do a fair investigation, like we always do, but I couldn't understand why so much involvement from my senior management staff about [the veteran], because we don't get that from anybody else." He continued, "[W]e don't get visits from Mr. Connell or anybody at his level on any other investigations . . . or a call from my senior chief about a video."

The involvement of senior VA leaders required VA police to respond to potentially distracting requests of non-law enforcement leaders at the outset of the investigation and risked introducing bias to the investigation by redirecting the focus of investigators. In this case, the OIG determined that the withdrawal of VA police from the investigation after independent OIG criminal investigators took charge prevented the investigation from becoming tainted by these initial investigative steps. Nonetheless, two events during the special meeting on Monday, September 23, 2019, highlight the risks posed by the direct involvement of senior VA officials, which distracted VA police efforts away from fully investigating the alleged assailant:

- A VA police officer in attendance told OIG investigators that someone at the special meeting mentioned that the veteran had made similar complaints in the past.⁵³ The VA police officer also told OIG investigators that the VHA senior security officer repeated a statement to the same effect in a conversation later the same day.
- While the meeting was underway, a VA police officer obtained and circulated a public records background report on the veteran who made the complaint.⁵⁴ VA police did not run a background report on the contractor until two days later even though he had already been identified by VA police.⁵⁵

⁵³ The police officer could not remember which of the attendees made the comment, but he distinctly recalled that the individual was male and was not a member of the VA police service.

⁵⁴ The background report obtained on the veteran included contact information, prior addresses, political donations, voter registrations, small business registrations associated with her addresses, automobile registrations, aliases, relatives, known associates, and other material useful to law enforcement. In this instance the background report was obtained from a Thompson Reuters subscription service called CLEAR that consolidates nationwide information from law enforcement databases, public records, and other sources of information about the subject of the report. CLEAR reports also contain information about arrests, warrants, and judgments (none were indicated on the veteran's report). In support of this administrative investigation, the OIG obtained a CLEAR report on the contractor. Had VA police obtained this report when they obtained the report on the veteran, they would have learned that the contractor had a criminal history.

⁵⁵ The OIG located a report that the primary VA police officer obtained on the individual who was the subject of the allegations two days later on September 25, 2019.

The senior security officer told OIG officials that when he served as a criminal investigator it was his personal practice to always run a background check on the “suspect and the victim.” When OIG investigators asked about the content of the information obtained on the complainant in the background check, the senior security officer acknowledged that there may have been a reason why the background check was run in this instance. He testified, “[N]ow that you mention it, that point about [whether] she’s done this before, maybe that’s why they wanted to see if there’s been a complaint in the past where law enforcement was involved in a sexual assault investigation.” Two other VA police officers present during the meeting told OIG investigators that it was unusual to run a background check on a complainant.⁵⁶

The primary VA police officer working the case was not present during the special meeting. When asked by OIG investigators whether she was aware that a background report had been requested on the complainant, the officer stated that no one had mentioned this to her and elaborated, “I don’t actually see why we would be trying to pull up dirt on the victim or alleged victim until we have reasonable suspicion to start thinking something doesn’t add up here.”

Apart from the focus on the veteran’s background during the special meeting, the OIG determined that between September 20 and 26, two of the VA police officers involved in the investigation had also reviewed news stories about the veteran, and one obtained a copy of the veteran’s résumé from the internet, which was then circulated to her superior officer.

Finding 2 Conclusion

The OIG found substantial evidence that Secretary Wilkie and other senior VA officials doubted the veteran’s allegations almost immediately after learning of them. Initial communications among VA officials questioned whether the veteran had been involved in making prior complaints and speculated about whether the HVAC chairman was “laying the grounds for a spectacle.” In addition, the visits by senior VHA officials to the medical center increased pressure on the VA police and risked interfering with or introducing bias to the criminal investigation had it not been transferred to the independent OIG.

The OIG determined that any impact on the initial VA police investigation did not harm the OIG criminal investigation into the veteran’s allegations and therefore makes no recommendations.

⁵⁶ The medical center associate director told OIG investigators that he had been a police officer for 38 years. He agreed with the two officers who thought this was unusual, testifying, “I don’t think you would do that for the complainant. You would do all of that for a suspect.”

Finding 3: Multiple VA Officials Testified that Secretary Wilkie Remarked that the Veteran Made, or May Have Made, Prior Similar Complaints

Eight senior VA officials with personal knowledge told OIG investigators about discussions in Secretary Wilkie's presence that involved the veteran's purported history of filing complaints, whether specific to prior sexual assault allegations or other issues that arose during her military service.⁵⁷ Six of these witnesses attributed the remarks to Secretary Wilkie himself. Although these witnesses did not have a verbatim recollection of the words used by the Secretary, they were generally reported to be words to the effect that she made similar complaints or "she may have done something like this before." Multiple witnesses told OIG investigators that they understood the implication to be that the veteran had brought forward frivolous allegations in the past. As detailed in this section, witnesses recalled Secretary Wilkie making these remarks in various contexts as early as September and October 2019 and again in December 2019 in connection with information the Secretary may have received from Congressman Dan Crenshaw. In contrast to finding 1 regarding whether the Secretary investigated the veteran, or directed others to do so, this finding examines statements attributed to Secretary Wilkie by other VA personnel in OIG testimony.

In his testimony before OIG investigators, Secretary Wilkie denied using government time or resources to discredit the veteran and denied attempting to collect information about the veteran's military service and credibility. OIG investigators were unable to re-interview him to clarify his statements in light of the following testimony subsequently provided by other VA officials.

As Early as September 2019 Secretary Wilkie Began Telling VA Officials that the Veteran Previously Made Similar Complaints

Less than a week after the veteran reported being sexually assaulted, Secretary Wilkie made a surprise visit to the DC medical center on Thursday, September 26, 2019. After attending a reception, he met with VA police to thank them for their service. Subsequently, he and Chief of Staff Pamela Powers met with the medical center director. According to a contemporaneous email sent by the medical center director to VHA Executive in Charge Dr. Richard Stone, the meeting lasted "about 35–40 minutes and [they] discussed the alleged sexual assault and HVAC engagement in detail." During his meeting with the medical center director, Secretary Wilkie read the written statement provided to the VA police by the veteran, detailing her account of the

⁵⁷ Three other individuals who were not senior VA officials testified to participating in conversations in which VA officials other than the Secretary made comments indicating that there was a belief that the veteran had made prior complaints. Two of these individuals attributed the comments to Mr. Hudson, and the third attributed the comments to the deputy assistant secretary for congressional and legislative affairs. Mr. Hudson and the deputy assistant secretary denied making such comments.

incident. The medical center director told OIG investigators that after he finished reading, Secretary Wilkie commented that the veteran's statement was "'similar to other complaints she's made other places,' or words to that effect." VA Deputy Assistant Secretary for Public Affairs Curtis Cashour reported a similar comment to OIG investigators and testified that he specifically recalled hearing from Secretary Wilkie, and also separately from Assistant Secretary for Public and Intergovernmental Affairs James Hutton, that the veteran "may have done this sort of thing in the past." Mr. Cashour could not pinpoint the timing of these conversations but indicated that the discussions were not part of any formal meetings. As discussed in finding 4, Mr. Cashour acted on the information he heard from Secretary Wilkie.⁵⁸

In addition to the comments made by Secretary Wilkie to the medical center director and Mr. Cashour, another senior official provided sworn testimony to OIG investigators that in October 2019, Secretary Wilkie discussed the veteran during a daily staff meeting (referred to as the "morning sync" meeting) and commented that the veteran "had made an allegation before of sexual assault."⁵⁹ According to this attendee, the Secretary made similar remarks from time to time during subsequent meetings.⁶⁰

Attendees of the morning sync meetings had varying recollections:

- As discussed in detail below, Ms. Powers and Mr. Tucker recalled Secretary Wilkie making comments about the veteran's reputation based on information they understood he received from Congressman Crenshaw.⁶¹
- Senior Advisor John Mashburn told OIG investigators that he recalled a conversation at a morning sync meeting where a meeting attendee told those present that someone at a social event the prior evening had relayed to the attendee that the veteran had "made complaints of harassment" while in the military. Mr. Mashburn could not recall which attendee made the comment and neither attributed the remark to Secretary Wilkie nor ruled out that he could have said it.
- A senior advisor who regularly attended the morning sync meeting recalled hearing a VA official describing the veteran as a "serial complainer," but the senior advisor could not attribute this comment to a particular individual and could not determine whether it was stated during the morning sync meeting or at some other meeting.

⁵⁸ See finding 4, p. 27.

⁵⁹ This testimony was consistent with statements made to the OIG by former Deputy Secretary James Byrne in which he described Secretary Wilkie as "obsessed" with the veteran's allegations and stated that he recalled the Secretary raising the topic on "multiple occasions" in conversations starting as early as mid-October 2019.

⁶⁰ Routine attendees of the morning sync meeting include senior political appointees such as Mr. Byrne, Ms. Powers, Mr. Hutton, Assistant Secretary for Congressional and Legislative Affairs Brooks Tucker, and Acting General Counsel William Hudson Jr. The meeting was also attended at times by senior advisors and other members of the Secretary's immediate staff, including both career and political appointees.

⁶¹ See below, p. 23.

OIG investigators asked what the prior complaints were, and the senior advisor stated, “[T]here was something said along the lines of she was in the military before and had complained before.”

- Two regular attendees of the morning sync meeting, the deputy chief of staff and the chief financial officer, did not recall any conversations about prior complaints that may have been made by the veteran. Other than the general statements by some morning sync attendees that this topic was discussed during some meetings, the OIG did not develop evidence that specifically conflicted with the testimony of either individual, nor was the OIG able to rule out the possibility that the discussions occurred at times when they were not present, such as during the smaller “stay behind” meetings that sometimes followed the larger meeting.
- Mr. Hutton testified that he did not recall discussions at morning sync meetings about the veteran having made prior complaints. When asked whether he recalled such conversations outside of the morning sync meetings, Mr. Hutton stated that he was aware of “nothing beyond what [he had] read publicly” in the media. This appears inconsistent with Mr. Cashour’s specific recollection (discussed in more detail in finding 4) that he first heard about the veteran having made a prior complaint from Mr. Hutton and later from Secretary Wilkie.⁶²
- Mr. Hudson told OIG investigators that he did not recall the veteran being discussed at morning sync meetings and did not recall Secretary Wilkie ever indicating that he had any information about her having raised similar allegations in the past. However, two senior VA attorneys told OIG investigators that they recalled hearing Mr. Hudson comment that the veteran had made prior frivolous complaints of sexual harassment or similar offenses. One of these attorneys provided handwritten notes of a conversation she had with Mr. Hudson in which he conveyed information to her about a letter he wanted her to draft on behalf of the Secretary. As reflected in figure 2, the attorney’s notes state, “[W]e know she’s done before.” The attorney told OIG investigators that this reflected Mr. Hudson’s statements to her, and that she recalled him mentioning that the veteran had

⁶² Mr. Hutton declined a request for a follow-up interview, and therefore the OIG could not ask him about this apparent inconsistency.

complained of sexual harassment or assault in connection with a performance evaluation while in the military.

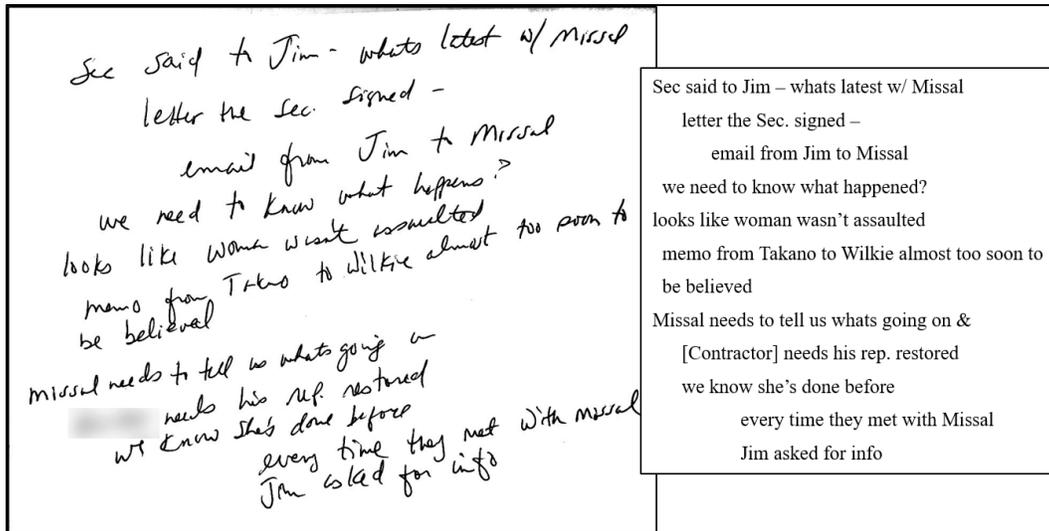


Figure 2. Undated notes taken in January 2020, redacted to de-identify the contractor.
Source: VA.

In addition to the political appointees mentioned in the above bullets, the OIG interviewed two executive support staff members (permanent career appointees) who also attended the morning sync meetings. Neither recalled statements made about the veteran.

Secretary Wilkie’s Testimony Regarding a Discussion in December 2019 with Congressman Crenshaw about the Veteran Was Inconsistent with Other VA Officials’ Statements

Secretary Wilkie attended a fundraiser on December 4, 2019, which Congressman Crenshaw also attended. According to Secretary Wilkie, Congressman Crenshaw approached him at the event and raised the topic of the veteran and the media reports of her allegations. In his interview with OIG investigators, Secretary Wilkie stated that Congressman Crenshaw said he served in the same unit as the veteran in the U.S. Navy. Secretary Wilkie told OIG investigators that he “related the conversation with Mr. Crenshaw” during the morning sync meeting. Secretary Wilkie testified that he did not discuss the veteran with Congressman Crenshaw “other than the fact that [Congressman Crenshaw had] seen the [media] reports [and] that he just mentioned that he’d served in the same unit.” Congressman Crenshaw declined the OIG’s request for an interview. However, in two separate media interviews, Congressman Crenshaw denied ever

discussing the veteran with Secretary Wilkie.⁶³ When asked in one of those interviews why Secretary Wilkie sent an email to other VA employees stating that he had discussed the veteran with him, Congressman Crenshaw speculated that the Secretary may have mentioned his name because the timing coincided with a meeting he had with the Secretary.⁶⁴

According to security logs, Secretary Wilkie departed the fundraiser at 7:17 p.m. He emailed Mr. Tucker and Ms. Powers at 7:21 p.m. commenting, "Ask me in the morning what Congressman Crenshaw said about the Takano staffer whose glamor shot was in the New York Times."

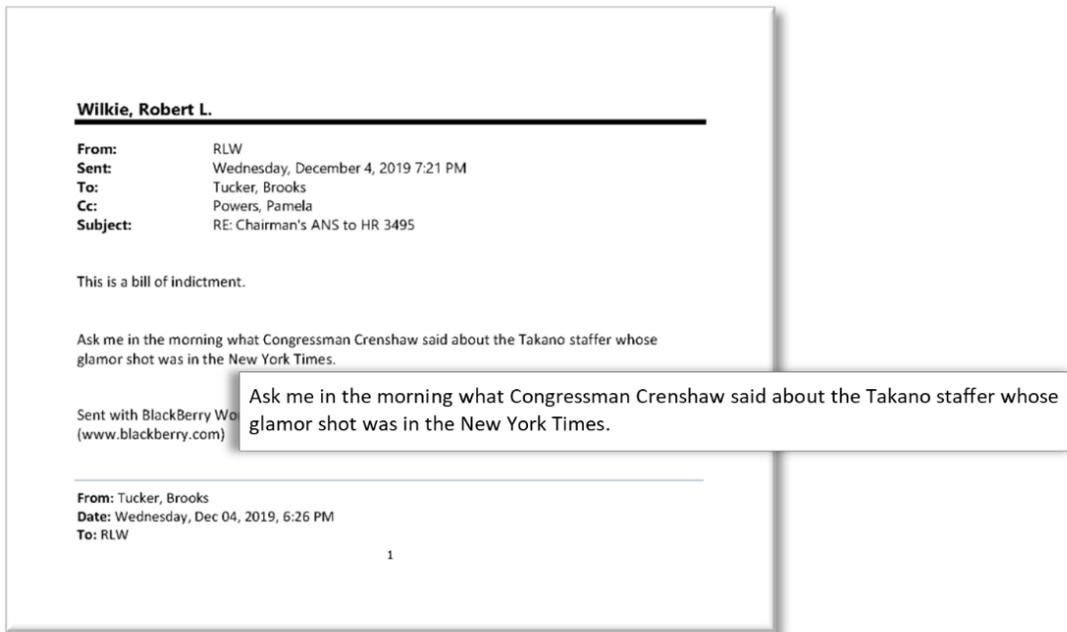


Figure 3. Excerpt of December 4, 2019 email from Secretary Wilkie.
Source: VA.

⁶³ Isaac Arnsdorf, "VA Secretary Looked for Dirt on a House Staffer Who Reported Sexual Assault in a VA Hospital, Complaint Says," *ProPublica*, February 7, 2020; Naveed Jamali, Tom O'Connor, and Ramsey Touchberry, "Former VA Official Claims Refusal to Discredit Female Veteran Who Complained of Sexual Assault Led to Firing," *Newsweek*, November 19, 2020.

⁶⁴ In response to a request made on November 20, 2019, by Congressman Crenshaw, Secretary Wilkie hosted him for breakfast on December 19, 2019. The scheduled topic of discussion related to VA rates for disability and compensation. At Secretary Wilkie's request, there were no other participants in the breakfast. At least one witness told OIG investigators that it was unusual for the Secretary to meet with a member of Congress for a policy discussion without having other VA officials with subject matter expertise present. Other witnesses told the OIG that it did not seem unusual. OIG analysis of the Secretary's calendar for the period September 23, 2019, to January 14, 2020, identified 14 meetings with members of Congress. The meeting with Congressman Crenshaw was the only one-on-one meeting. In public statements, Secretary Wilkie and Congressman Crenshaw denied discussing the veteran during the breakfast meeting.

When presented with the email excerpted in figure 3, Secretary Wilkie maintained that the only information he recalled being imparted by Congressman Crenshaw was that the congressman had served with the veteran in the Navy. OIG investigators asked why information about them serving together, on its own, would be sufficiently remarkable to merit an email about passing that mention along to Mr. Tucker and Ms. Powers. Secretary Wilkie stated, “Well I don’t remember. I have no idea.” Secretary Wilkie told OIG investigators that the “glamor shot” remark referred to a photo of the veteran that accompanied the news story about her allegations in September 2019, and he expressed regret that he had made the remark.⁶⁵

Secretary Wilkie’s testimony does not fully align with the statements made to the OIG by Ms. Powers, Mr. Tucker, and Mr. Byrne:⁶⁶

- Ms. Powers stated that Secretary Wilkie, in relating a conversation he had with Congressman Crenshaw, “might have said something to the fact that, [the veteran] made allegations in the military as well when [Congressman Crenshaw and the veteran] served together or something to that effect.”
- Also in reference to Secretary Wilkie relating a conversation with Congressman Crenshaw, Mr. Tucker told OIG investigators that Secretary Wilkie conveyed that the veteran had “some issue or trouble in the Navy at some point” and elaborated that the veteran was “having some trouble with personal issues or command, command relationship issues.”
- Mr. Byrne told the OIG that Secretary Wilkie claimed to have confirmed with Congressman Crenshaw’s information that the veteran had previously filed frivolous complaints while the two were on active duty together.⁶⁷

In addition to the above witness testimony, OIG investigators identified other documentary evidence confirming that individuals within VA understood the content of Congressman Crenshaw’s communication with Secretary Wilkie included information suggesting that the

⁶⁵ Another witness told OIG investigators that they recalled Senior Advisor Mashburn using the term “glamour shot” in conversations referencing the veteran. Mr. Mashburn recalled having used the term himself.

⁶⁶ Because attendance was not kept, OIG investigators were unable to identify the attendees at the morning sync meeting held on December 5, 2019. Other than Mr. Tucker, Ms. Powers, and Mr. Byrne, none of the other routine attendees of the morning sync meeting recalled Secretary Wilkie commenting on his communication with Congressman Crenshaw the prior evening. Mr. Mashburn testified that during a morning sync meeting an attendee reported having been approached at a reception the “night before” and was told that the veteran “had made similar complaints during her military career.” Although these circumstances are similar to the fundraiser setting where Secretary Wilkie interacted with Congressman Crenshaw, Mr. Mashburn could not attribute the comments to Secretary Wilkie, nor could he identify the other person except as a “former military” person.

⁶⁷ In public statements responding to questions about whether he shared information about the veteran with Secretary Wilkie, Congressman Crenshaw has denied doing so and has been quoted (in the November 19, 2020 *Newsweek* article) saying, “If you really want to know what are the things I know about [the veteran], then by all means, but I’ve no intention of slandering her, nobody’s ever asked me to.”

veteran had previously made false accusations. A VA attorney emailed a colleague on May 25, 2020, describing the email Secretary Wilkie wrote regarding conveying Congressman Crenshaw's statement about the veteran (excerpted in figure 3) as reflecting "an issue about an accuser's past possibly false accusations."⁶⁸ Based on this evidence and the conflicting testimony provided by other VA officials, the OIG determined that Secretary Wilkie's testimony regarding the content of his communication with his staff concerning the information received from Congressman Crenshaw was incomplete or incorrect. The OIG was unable to reconcile Secretary Wilkie's testimony because he declined to agree to a follow-up interview.

Finding 3 Conclusion

Comments attributed specifically to Secretary Wilkie by six senior VA officials reflect that on multiple occasions he stated or questioned whether the veteran had made similar prior complaints, remarks that some witnesses interpreted as implying that her previous allegations were false. According to email records, Secretary Wilkie reported having had a conversation with Congressman Crenshaw about the veteran. Three witnesses told the OIG that Secretary Wilkie relayed to them that the congressman provided information about the veteran having made prior complaints during active duty in the U.S. Navy. The documented discussion between VA attorneys about the potential release of Secretary Wilkie's follow-up email regarding Representative Crenshaw also supports that the content of the email related to possibly false prior accusations by the veteran. Statements made to the contrary could not be addressed because of refusals to cooperate further with OIG investigators.

Although unprofessional and disparaging, the OIG identified no violation of law, regulation, or policy in connection with the statements reported to have been made by Secretary Wilkie to other VA officials concerning the veteran, and therefore makes no formal recommendations.

⁶⁸ The two attorneys were analyzing the email in connection with preparing VA's response to a Freedom of Information Act request that potentially called for the disclosure of the email to the requestor.

Finding 4: VA Officials Attempted to Focus the National Media on the Veteran's Background and Credibility

Skepticism about the veteran's motives and credibility appears to have set the tone for efforts by VA officials to divert media coverage away from the substance of her complaint to the veteran herself.⁶⁹ This effort was evidenced by an off-the-record suggestion made by Deputy Assistant Secretary for Public Affairs Curtis Cashour to a journalist that the veteran's background should be examined, as well as by VA officials' deliberate efforts to have an incorrect characterization published that her claims lacked merit. The conduct of VA officials in both regards is not consistent with VA's stated objective to ensure that its facilities are safe and welcoming places for all veterans to enter and receive care and services. Nor is their conduct aligned with principles of being respectful of individuals who come forward with complaints involving VA personnel and facilities.⁷⁰

A Senior VA Official Told a Journalist to Look into the Veteran's Background Based on Comments Made by Secretary Wilkie

On September 25, 2019, Deputy Assistant Secretary for Public Affairs Cashour drafted a statement responding to a journalist who was asking for comment about the sexual assault complaint. The statement was distributed later that afternoon.

These are serious allegations and VA is treating them as such. The department has turned this matter over to VA's independent inspector general and other law enforcement and a criminal investigation is underway.

VA will not tolerate this alleged behavior, and we are committed to delivering justice. That's why, in order to protect the integrity of the investigation, we can't comment further.

VA's public position of not commenting further about the pending criminal investigation was not reflected in the off-the-record conduct of Mr. Cashour. He told OIG investigators that he had an off-the-record conversation with a journalist who routinely covers VA for a global media outlet.⁷¹ Mr. Cashour testified that during the conversation he advised the journalist, "[Y]ou may want to look into—see—if she's done this sort of thing in the past." He told OIG investigators

⁶⁹ See findings 2 and 3 for discussion of VA officials' skepticism of the veteran's motives and credibility.

⁷⁰ VA defines its core values as ICARE: Integrity, Commitment, Advocacy, Respect, and Excellence. These values "describe the organization's culture and character and serve as the foundation for the way VA employees should interact with each other, as well as with people outside the organization." 38 C.F.R. § 0.601. VA has also established a series of aspirational core characteristics, which include being "accessible" by "engag[ing] and welcom[ing] veterans and other beneficiaries, facilitating their use of the entire array of its services. Each interaction will be positive and productive." 38 C.F.R. § 0.602(b)

⁷¹ Citing company policy, corporate counsel for the journalist declined to approve the OIG's request to interview the journalist on a voluntary basis. The OIG lacks testimonial subpoena authority to compel the journalist's testimony.

that he based this suggestion on remarks he heard from Secretary Wilkie and VA's Assistant Secretary for Public and Intergovernmental Affairs James Hutton that the veteran had raised similar complaints in the past.⁷² In his testimony with OIG investigators, Mr. Cashour revealed that he had not verified whether the veteran made a prior complaint and that the only basis for the information he shared was what he heard from Secretary Wilkie and Mr. Hutton. He characterized his effort to bring attention to the complainant's credibility as being undertaken "in a discreet manner, not as sending a press release or having a press conference like this is absolutely true. Print it right now." Mr. Cashour was asked whether his intention was to "discredit" the veteran. He testified, "I think it was an effort to get all the facts out there or at least see what's out there." Mr. Cashour stated that he did this on his own initiative and was not operating under any direction from Secretary Wilkie to do so.

Former Deputy Secretary James Byrne told the OIG that on at least three occasions after Secretary Wilkie met with Congressman Crenshaw, the Secretary asked Mr. Byrne to figure out a way to distribute the information he had obtained about the veteran to the media.⁷³ Mr. Byrne stated that Secretary Wilkie also requested that Mr. Hutton contact the media and/or get Mr. Cashour to "do something" to get the information out. The implication that Mr. Cashour's contact with the media was done at Secretary Wilkie's direction was denied by both Secretary Wilkie and Mr. Cashour. Mr. Hutton also denied receiving such an instruction from Secretary Wilkie.

During his interview with the OIG, Mr. Cashour was unable to recall the exact timing of his communication with the journalist. OIG investigators were unable to explore this topic with him in greater detail, including discussing additional evidence gathered, because he declined the OIG's request for a follow-up interview. Analysis of his communications established a series of contacts between him and the journalist on September 25, 2019, the day before the story was released about the veteran's allegations. That afternoon the journalist emailed Mr. Cashour and his supervisor Mr. Hutton requesting "any comment or context" that either could provide concerning the sexual assault allegations raised by the veteran. Approximately an hour and a half after receiving the journalist's inquiry by email, telephone logs indicate that Mr. Cashour called the reporter, and the call lasted approximately eight minutes. Shortly after the call concluded, the journalist inquired of Mr. Cashour via email, "since it was VA police can't i request the report from you?"⁷⁴ The journalist published the article the next day, and it included VA's official

⁷² Note that Mr. Cashour's statement appears to conflict with Mr. Hutton's statement to OIG investigators that he did not recall such comments from the Secretary.

⁷³ Mr. Byrne informed the OIG that he would not do what Secretary Wilkie asked of him. Mr. Byrne attributes the downturn in his relationship with Secretary Wilkie to his refusal to cooperate with Secretary Wilkie's request.

⁷⁴ As of this exchange, VA police had recorded statements from the veteran and other potential witnesses. VA police had not yet compiled the report of investigation, summarizing the results. The OIG identified no other news stories in this time frame by this journalist that would have involved a request for a VA police report.

statement quoted above, but it did not include any mention of whether the veteran made prior complaints.⁷⁵

In addition, although there were multiple contacts between the journalist and Mr. Cashour in October and November, none coincided with reporting on the veteran's allegations until there was a flurry of emails between Mr. Cashour and the journalist on January 14, 2020, the day that the OIG notified VA the investigation had been closed. Mr. Cashour and the journalist had a 16-minute phone call that day. As discussed in the section that follows, the journalist did write an article on January 16 covering Secretary Wilkie's letter to Chairman Takano that characterized the allegations as "unsubstantiated" and referencing the controversy that the letter had generated.⁷⁶ That article also made no mention of rumors concerning the veteran's past.

Mr. Hutton told OIG investigators that he was aware that Mr. Cashour had told a journalist that "when these allegations were going to be [reported], to make sure you get all the facts right, which we say to reporters on a regular basis."⁷⁷ When asked whether he was aware of any information being provided to the media that might call into question the veteran's "account of her sexual assault or to tarnish her credibility as a complainant," Mr. Hutton stated, "No, not to my knowledge. The only thing, again, like—as I said before, is that I understand that, you know, we've told media to make sure you check out all the facts. But that's not giving them facts. That's saying check out the facts. That's not the same thing." Mr. Hutton's testimony on this point does not align with Mr. Cashour's testimony that he believed Mr. Hutton and Ms. Powers were "disappointed" in him for having had the conversation with the journalist "because it's going to come out, and it's, it's not going to look good. And you know, it's a—it makes us look bad."⁷⁸

On February 12, 2020, the same journalist wrote to VA's press secretary with a series of queries including, "I know that you all have previously denied that Mr. Wilkie and[/]or other officials at the VA went in pursuit of potentially damaging information about [the veteran's] prior claims *but I know this to be untrue*. Can you possibly fact check that?" (emphasis added). VA provided a written response to this query at 11:21 a.m. the next day, in which the press secretary wrote

⁷⁵ Jennifer Steinhauer, "Woman Trying to End Sexual Assault at V.A. Centers Says She Is Attacked in One.," *New York Times*, September 26, 2019.

⁷⁶ Jennifer Steinhauer, "No Charges in Assault Complaint at V.A. Hospital, and a Public Fight Erupts." *New York Times*, January 16, 2020.

⁷⁷ Mr. Hutton's phrasing, which connects this event to the initial publication of the allegations, suggests that Mr. Cashour's conversation was associated with the September 26, 2019, article in which the reporter first addressed the allegations.

⁷⁸ The OIG could not reconcile Mr. Cashour's testimony about Mr. Hutton's apparent disappointment and the seemingly contradictory testimony from Mr. Hutton that he believed Mr. Cashour's communication to be something commonly stated to reporters by VA press personnel. The OIG could not clarify apparent inconsistencies such as this because Mr. Hutton and Ms. Powers were interviewed before Mr. Cashour, and they declined the OIG's request for a follow-up interview.

“THIS WAS DISCUSSED DURING YOUR ON-THE-RECORD INTERVIEW.” The OIG determined that the journalist interviewed Ms. Powers and Mr. Hutton early on the morning of February 13, 2020. Mr. Hutton told OIG investigators that in this interview he told the journalist “I just don’t know of [Secretary Wilkie] trying to dig up dirt on [the veteran].” The journalist’s article, published later that day, quoted Ms. Powers as stating, “The secretary is the most ethical, decent, honorable man I have ever known. At no time did the secretary ever direct, discuss or insinuate that somebody should investigate [the veteran’s] background.” With respect to the journalist’s query that she “knew” to be false VA’s denials that officials sought discrediting information about the veteran, the article stated, “Senior aides to Mr. Wilkie flatly denied that he had orchestrated any effort to discredit [the veteran].”⁷⁹

VA’s Press Secretary Publicized to Multiple Media Outlets that the Veteran’s Allegations Were Unsubstantiated

The letter referenced above from Secretary Wilkie to Chairman Takano describing the veteran’s allegations as unsubstantiated was sent on January 15, 2020. The VA press secretary also wrote to at least nine media outlets alerting them to the attached letter from Secretary Wilkie. The press secretary’s transmittal message to the media outlets stated, “I thought you’d be interested in covering the fact that federal investigators didn’t substantiate DC VA allegations and closed the case with no charges.” A journalist responded seeking clarification: “[T]o be clear, are you saying the incident was made up? Or simply that there wasn’t evidence enough to do anything about it?” The VA press secretary responded,

As the secretary says to Chairman Takano in the letter: ‘Based on our most recent discussions with VA Inspector General Missal and officials in the U.S. Department of Justice, we understand that the matter is now closed, and no charges will be filed. We believe that VA is a safe place for all Veterans to enter and receive care and services, but the unsubstantiated claims raised by you and your staff could deter our Veterans from seeking the care they need and deserve.’

The Secretary’s letter mischaracterized the allegations as unsubstantiated, and VA emphasized the mischaracterization when it distributed the letter to media outlets. When the press secretary repeated this paragraph in response to a reporter’s query about the veteran’s credibility, the commitment to that message remained unchanged. The day before the letter was sent, Inspector General Missal spoke by telephone with Mr. Byrne and Ms. Powers advising them that the investigation was being closed and that no charges were being filed. During the January 14 call, Ms. Powers asked whether it was acceptable for VA to respond to Chairman Takano that the investigation was closed due to a lack of merit. In response, Inspector General Missal

⁷⁹ Jennifer Steinhauer, “Veterans Affairs, a Trump Signature Issue, Is Facing Turmoil Again.” *New York Times*, February 13, 2020.

specifically cautioned that VA should not make characterizations beyond stating the investigation is closed without charges filed and should not comment on the merits.

VA Officials Intentionally Characterized the Veteran's Allegations as Unsubstantiated

Secretary Wilkie's statement that "unsubstantiated claims raised by [Chairman Takano] and [his] staff" could deter veterans from seeking care was met with criticism from several members of Congress and was widely reported.⁸⁰ VA subsequently told reporters that Secretary Wilkie "acknowledges that describing the allegations as 'unsubstantiated' was a poor choice of words, and he withdraws that word." Focusing on the allegations as "unsubstantiated" ignores that even if one removed or replaced that word, the sentence nonetheless represents a public rebuke by the VA Secretary of a veteran for bringing forward a claim of sexual misconduct in a VA medical center, an effort that was anticipated by the senior attorney who prepared the letter.

The senior attorney who drafted the letter told OIG investigators that she had not previously been involved in VA's response to the veteran's allegations. On January 14, Mr. Hudson directed the senior attorney to prepare a draft letter to Chairman Takano regarding the closing of the criminal investigation and provided her with guidance on what the letter should convey. Thus she drafted "the letter largely based on information that Mr. Hudson had conveyed to [her] about what should be in the letter to Congressman Takano, and [she] drafted it using certain words and tone based on that discussion with him." She specifically recalled that Mr. Hudson told her that the veteran had made similar allegations in the past, and she got the impression that he viewed her as a "chronic complain[er]."

The senior attorney told OIG investigators that as the letter was going through revisions, more information was shared with her about the veteran's allegations and she began to "feel badly about the way [she] wrote" the draft letter. She told OIG investigators that her concern emanated from the combative tone of the letter as compared to the "sympathetic and reasonable" impression she formed of the veteran after reading her public statements describing the incident. Emails reflect that the senior attorney told Mr. Hudson that she was concerned that the letter was "overly vilifying" the veteran. The senior attorney proposed adding language to encourage

⁸⁰ HVAC, "Chairman Takano, Congresswoman Brownley Shame VA for Flippant Response to Sexual Assault Allegations," news release, January 15, 2020, <https://veterans.house.gov/news/press-releases/chairman-takano-congresswoman-brownley-shame-va-for-flippant-response-to-sexual-assault-allegations>; Letter from Sen. Patty Murray et al. to VA Secretary Robert Wilkie, February 24, 2020; Victoria Chamberlin, "After Alleged Sexual Assault, Veterans Say Officials Aren't Doing Enough to Make the D.C. VA Safe for Women," *DCist*, January 17, 2020; Jennifer Steinhauer, "Veterans Affairs, a Trump Signature Issue, Is Facing Turmoil Again," *New York Times*, February 13, 2020; Lisa Rein, "VA Chief Wilkie Sought to Dig Up Dirt on Woman Who Complained of Sexual Assault, Agency Insiders Say," *Washington Post*, February 8, 2020; Steve Benyon, "VA Chief Wilkie Wants to Reexamine Alleged Sexual Assault That He Called Unsubstantiated," *Stars and Stripes*, February 5, 2020; Leo Shane III, "Complaint Accuses VA Secretary of Working to Discredit Hill Staffer Who Reported Sexual Assault," *Military Times*, February 7, 2020.

veterans to report incidents as the veteran did and to substitute the phrase “the publication of claims that cannot be substantiated” in place of “the unsubstantiated claims raised.” In her email transmitting the proposed revision to Mr. Hudson, the senior attorney wrote that the suggestion was an “attempt to edit in a way that will be less likely to deter women Veterans from coming forward if they suffer harassment or assault.” She told OIG investigators that Mr. Hudson was “dismissive” of her proposed revisions and maintained that the tone of the original draft was “not inappropriate.” Emails reflect that Mr. Hudson ultimately did forward the senior attorney’s proposed revised draft to the deputy chief of staff and others working on the letter, writing, “Would attached version be a bit more acceptable [or go with] version previously submitted?” The deputy chief of staff responded that the Secretary had already approved the prior version, and it was being finalized. Mr. Hudson did not engage further.

A “Provocative” Draft Media Release Demonstrates that Some VA Leaders Sought to Publicly Refute the Veteran’s Allegations

While VA officials were finalizing Secretary Wilkie’s letter to Chairman Takano, Mr. Hutton circulated a draft statement to other VA officials to consider sending to a media outlet. He described the draft statement as “designed to be very strong” and “provocative.”

For nearly four months, VA’s independent inspector general as well as the Department of Justice – including the head of the sex crimes division for the U.S. Attorney’s Office for the District of Columbia – thoroughly investigated these allegations and identified no wrongdoing or any basis for criminal charges. This case is now closed.

This is nothing short of an exoneration for the Washington DC VA [Medical Center].

It is now incumbent upon Chairman Takano and his staff to explain why these serious allegations, which they forcefully and repeatedly broadcast as fact, failed to withstand basic scrutiny.

The OIG did not locate evidence of this statement being released by VA. It does, however, provide insight into the attitude of some VA officials toward the veteran’s allegations, and it aligns with what the senior attorney who drafted the “unsubstantiated” letter described as the tone and substance that Mr. Hudson told her was intended for VA’s response to the news that the joint OIG-USAO investigation had been closed without charges.

Finding 4 Conclusion

The OIG found that VA’s deputy assistant secretary for public affairs suggested that a journalist for a global media outlet look into the veteran’s background. Although he testified that he was not directed to do this by anyone at VA, he said that his actions were based on statements made by Secretary Wilkie and by his supervisor, Mr. Hutton. The OIG also determined that, despite

being cautioned by Inspector General Missal to the contrary, VA officials deliberately sought to characterize the closure of the criminal investigation as evidence that the veteran's claims lacked merit and pushed this incorrect and misleading information to at least nine media outlets. The conduct of VA officials in both regards does not appear consistent with VA's stated principle to treat all veterans with respect. Nor does it further VA's objectives of ensuring that its facilities are safe and welcoming places for all veterans. Whether this conduct is sufficiently inconsistent with VA's policy objectives to warrant administrative action is a matter entirely within the judgment of VA officials who are already aware of the operative facts, and therefore the OIG makes no formal recommendations.

Finding 5: VA Leaders Did Not Fully Consider or Take Appropriate Administrative and Other Corrective Actions Despite Having Access to Relevant Information

On September 20, 2019, when Chairman Takano first wrote to Secretary Wilkie about the veteran's allegations, he included a series of requests for VA to address accountability for the immediate incident and to take proactive measures to prevent such incidents from recurring. This section addresses VA leaders' failure to determine if administrative action or other remedial efforts were appropriate to ensure that the Washington DC VA Medical Center is a safe and welcoming healthcare facility for everyone. The following determinations support the OIG's findings:

- VA officials did not take steps to determine if action involving the contractor was warranted—using information from the VA police files, to which the OIG pointed them, or the medical center director's and associate director's files.

Had VA officials considered that information, they would have seen that the contractor was the subject of a May 2019 sexual harassment complaint and had previously been convicted of criminal offenses. Those offenses included armed robbery and various armed and unarmed drug offenses, which are potentially relevant to the outcome of a background check required for access to the facility. Further analysis would have revealed that no such background check has ever been conducted.

- VA failed to take effective steps to address an environment within the medical center known to be inhospitable to women.

VA Officials Did Not Take Steps to Determine Whether the Contractor Should Be Subject to Any Administrative Action

Inspector General Missal unambiguously communicated to VA senior leaders that, once the criminal investigation is closed, VA management is permitted to take administrative action as it deems appropriate. Even before the OIG-USAO criminal investigation was closed, OIG investigators notified VHA management about safety issues revealed during the criminal investigation for VA follow-up. Once the criminal investigation was closed, the inspector general responded to VA senior officials' inquiries about accountability by reminding them that they had access to VA police records within the medical center regarding the contractor that, if reviewed, would help inform whether administrative or other action was appropriate. VA leaders failed to

consider available information or undertake an administrative investigation and instead decided that they would attribute their inaction to the lack of a “full accounting” from the OIG.⁸¹

The OIG Advised the Secretary and Senior Staff That They Could Take Any Action They Determined Was Warranted

Inspector General Missal informed VA leaders on January 14, 2020, that the criminal investigation was closed without any charges being filed. On January 23, 2020, Inspector General Missal met in person with Secretary Wilkie, then Deputy Secretary James Byrne, and Chief of Staff Pamela Powers to discuss various matters, including the closed criminal investigation into the veteran's allegations. Mr. Byrne explained that the absence of a report from the OIG made it difficult for VA to determine whether administrative accountability measures might be appropriate or necessary. Mr. Missal responded that, although the OIG was limited in what it could disclose about the closed joint OIG-USAO criminal investigation, it was the OIG's practice in all of its matters to immediately inform VA staff whenever it becomes aware of anything exigent related to safety of patients or property.⁸² For example, during the criminal investigation, VA took corrective action after the OIG informed VA leaders that at least one security camera was not working.⁸³ In addition, OIG investigators conveyed information about the contractor's criminal history to VA police in September 2019.

Following the January 23rd meeting, Inspector General Missal emailed Mr. Byrne to reiterate that VA could take administrative action, specifically pointing out that VA police at the facility may have a file on the matter already:

Jim, as we have closed the investigation, there is no limitation on the Department conducting its own investigation to determine if any disciplinary or other action is appropriate. For example, staff and concessionaires can be interviewed about the events at issue. The VA Police at the facility may already have a file open. This should allow the Department to obtain the necessary information to make an informed decision.

Mr. Byrne forwarded this email to Secretary Wilkie, who acknowledged receipt.

⁸¹ In an email chain on January 21, 2020, discussing talking points regarding the closure of the criminal case, Acting General Counsel Hudson wrote that, if the topic was raised, Secretary Wilkie should “stress the VA IG should present a full accounting of the closed investigation to the VA Congressional Committees of Oversight.”

⁸² Neither the OIG nor the U.S. Department of Justice releases law enforcement investigation reports as a matter of course. VA OIG Directive 51 201, *Case Initiation, Management, and Control*, March 19, 2012; U.S. Dept. of Justice, Just. Manual §1-7.100 (2020).

⁸³ Unrelated to the veteran's report of sexual assault, VHA had initiated a nationwide surveillance system review on August 27, 2019. On November 21, 2019, after learning about the inoperable camera at the Washington DC VA Medical Center, VHA expanded the scope of this initiative to include a functionality assessment of surveillance systems controlled by the Veterans Canteen Service.

Had VA Leaders Accessed Available Information, They Would Have Learned the Contractor Had a Criminal Record and Had Been the Subject of a Sexual Harassment Complaint Four Months Earlier

Although Inspector General Missal specifically directed senior leaders to the VA police file, they never accessed readily available information about the contractor. Secretary Wilkie told OIG investigators that his paramount concern in this matter was to learn whether the medical center was a safe facility. During his interview, he relayed that he had been told the contractor was on probation and that he was “very concerned” but “did nothing” for the reasons discussed more fully below.

After an OIG investigation is completed, VA often will conduct its own administrative investigation to determine whether there is action that needs to be completed. Here, however, VA leaders did not conduct an administrative investigation, nor did they take any other action to determine whether accountability actions were necessary or appropriate with respect to the contractor. If VA officials had accessed information in the VA police file and the files of the medical center director and associate director, they would have seen information that likely would have raised red flags and prompted additional follow-up. Specifically, they would have discovered, as the OIG did in this investigation, that the contractor had a potentially problematic criminal history and had been accused of sexual harassment by a medical center employee just four months before the veteran reported being sexually assaulted.

First, the VA police report from October 2019 indicated that the contractor had a “colorful criminal history.”⁸⁴ Consideration of the contractor’s criminal history may have raised questions about how the individual had cleared the requisite background check to be issued the credentials necessary to access the facility. Indeed, one VA police officer told OIG investigators that he recalled a discussion among the VA police in which they collectively discussed the accused’s criminal history and wondered aloud, “[H]ow did he even get a PIV [personal identity verification] badge?”

A PIV badge should be issued to any VA employee or other individual who works in a medical center for more than 180 days in a year.⁸⁵ One purpose of VA’s credentialing program is to ensure the safety and security of VA facilities.⁸⁶ Prerequisites for the issuance of a PIV include

⁸⁴ As mentioned above, OIG investigators determined that the contractor’s criminal history included multiple convictions, including for armed robbery and various armed and unarmed drug offenses.

⁸⁵ VA Handbook 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, March 24, 2014.

⁸⁶ VA Handbook 0735. Identity credentials provide “the attributes of security, authentication, trust, and privacy and can be used to verify identities in order to enter federal buildings.”

fingerprinting and a background check.⁸⁷ While a criminal past is not per se disqualifying for VA employee or contractor credentialing, it is a consideration that may result in denial of the PIV badge.⁸⁸

Here, the contractor had been working at the medical center since at least 2017, exceeding the six-month criterion. However, the medical center told OIG investigators that no background check had ever been conducted on this individual, and that no PIV had been issued. Prior to the OIG's inquiry during this administrative investigation, the OIG identified no evidence that anyone at VA had investigated further and learned that the individual did not have appropriate credentials to enter the facility. On October 1, 2020, OIG investigators reported this to the medical center director to take whatever action he deemed appropriate. The medical center director responded that the contractor is not currently working at the facility due to COVID-19-related restrictions on access to the facility. The medical center director represented that he would ensure that the contractor and any other contractors are properly credentialed with appropriate background checks before returning to work in the facility. He also said he followed up with the contractor's supervisor to ensure that new contractors will be properly processed, background-checked, and credentialed before gaining access to the facility.

Second, information in the files of the medical center director and associate director revealed that a female medical center employee had lodged a formal complaint alleging that the contractor had been making unwelcome comments of a sexual nature to her over an extended period. Although no physical contact or threat was raised, the alleged comments were inappropriate for the workplace. The associate director of the medical center received the complaint and, without undertaking any investigation, referred the issue to the contractor's supervisor saying, "Please address the issue with the person in question and provide feedback to the complainant." After speaking with the contractor and a witness (who was represented to be the contractor's coworker), the supervisor filed a report of his inquiry that makes no conclusion as to whether the misconduct occurred, but instead notes that the contractor claimed the complaint was false and the witness claimed to have no knowledge of the alleged interaction. The contractor volunteered, without any admission of responsibility, to refrain from ever speaking to the female employee in the future. Had VA leaders been aware of or considered this information, they may have been prompted to consider whether the previous harassment complaint was properly handled and whether the two incidents taken together revealed a potential pattern of unacceptable behavior that required additional action.

⁸⁷ VA Handbook 0710, *Personnel Security and Suitability Program*, May 2, 2016; U.S. Office of Personnel Management Memo, "Final Credentialing Standards for Issuing Personal Identify Verification Cards under HSPD-12," July 31, 2008.

⁸⁸ U.S. Office of Personnel Management Memo, "Final Credentialing Standards for Issuing Personal Identify Verification Cards under HSPD-12," July 31, 2008; 5 C.F.R. § 731.202.

VA Could Have Conducted an Administrative Investigation

VA uses its own administrative investigations “for determining facts and documenting evidence about matters of significant interest to VA. Administrative Investigations are conducted to collect and analyze evidence to determine what actually happened and why it happened, so that individual and systemic deficiencies can be identified and effectively corrected.”⁸⁹ VA policy requires that

significant incidents occurring and issues arising within VA facilities or staff offices, or as a result of VA activities, shall be reported and investigated as necessary to meet the informational and decision-making needs of VA. Primary responsibility in this regard rests with the chief executive of the facility or staff office involved, and with their seniors in VA and its administrations.⁹⁰

While administrative investigations may be pursued for any number of reasons, VA policy requires a case-by-case determination of whether a full Administrative Investigation Board (AIB) is necessary when management officials become aware of significant incidents at VA facilities.⁹¹ VA policy governing administrative investigations identifies eight factors that management officials should use to guide their decision about whether to convene an AIB:

1. Impact of the matter on the facility, VA, government, veterans, and public interests generally, including financial impact;
2. Risk of adverse consequences from recurrence;
3. Need for objective, expert review and analysis of the matter;
4. Seriousness of any suspected misconduct, neglect, etc.;
5. Degree to which the cause and essential facts of the matter are known, subject to dispute, or unknown, and the potential for an investigation to determine additional relevant information;
6. Need for evidence to support corrective or disciplinary action or claims for or against VA [cross reference omitted];
7. Potential for adverse public, governmental, or media interest; and

⁸⁹ VA Directive 0700, *Administrative Investigations*, March 25, 2002.

⁹⁰ VA Directive 0700.

⁹¹ VA Handbook 0700. When evidence of criminal activity is discovered during an investigation, the AIB must be suspended until a law enforcement investigation is completed.

8. Other investigations being conducted into the same or closely related subject matter, and the availability and adequacy of those investigations to meet VA's informational needs.⁹²

Applying these criteria, OIG investigators are unaware of any facts that militate against conducting an AIB. Indeed, factor eight specifically contemplates the circumstance present here: the unavailability of investigative results from the joint OIG-USAO criminal investigation to fully meet VA's informational needs.

However, when asked during his OIG interview about VA conducting an administrative investigation in this matter, Secretary Wilkie responded, "Absolutely not. They're accusing me of running an independent investigation. . . . And I don't have a report from [the OIG]." He repeatedly expressed frustration that the OIG would not release a report of its criminal investigation to VA after the matter was closed on January 14, 2020. Secretary Wilkie's advisors prepared talking points for him on January 21, 2020, including a talking point seeking a "full accounting" from the OIG, to which the Secretary responded, "Goal is to put the shoe on the IG foot—agreed." Secretary Wilkie, Ms. Powers, Mr. Hutton, Mr. Tucker, and Mr. Cashour all repeated some variation of this talking point during their testimony with OIG investigators. In her August 5, 2020 interview, Ms. Powers also told OIG investigators that she believed VA was facing a no-win situation: "Can we do another investigation? Sure. But guess what will be on the front page of the paper: that we're doing another investigation to try and discredit [the veteran], even though that's completely false."

The Secretary's assertion that he could not act without a report or "full accounting" from the OIG has no merit. Although the OIG has the discretion to provide investigative summaries or reports to VA to allow it to take administrative action in appropriate cases, neither the OIG nor the U.S. Department of Justice releases law enforcement investigation reports as a matter of course.⁹³ This is particularly true in the case of sensitive matters, such as those involving allegations of sexual assault. Here, the OIG did provide VA police and senior leaders with important safety information and made clear that VA leaders could conduct additional follow-up with respect to the contractor and as to other issues identified at the medical center. VA police

⁹² VA Handbook 0700.

⁹³ VA OIG Directive 51 201, *Case Initiation, Management, and Control*, March 19, 2012; U.S. Dept. of Justice, Justice Manual §1-7.100.

were aware as of September 2019 that the contractor had a criminal history, and VA was told of safety concerns as they were identified during the OIG's investigation in order to take corrective action.⁹⁴

Further, Secretary Wilkie's and Ms. Powers' concerns about poor media coverage if they undertook an administrative investigation did not seem to take into account that VA already had information about the contractor that might prompt corrective action, without even the need to launch an investigation. In fact, Inspector General Missal specifically suggested Secretary Wilkie, Mr. Byrne, and Ms. Powers check VA police files on the subject in January 2020. Even if an investigation was undertaken, VA officials routinely work with media to inform them about the scope of their activities and could have done so proactively in this case.

VA's failure to even consider whether administrative action against the contractor was appropriate in light of readily available information at the medical center is inconsistent with Secretary Wilkie's stated concern with the safety of the facility. Instead of addressing the underlying concerns, VA engaged in a strategy of deflection by inappropriately stating its inaction was due to the lack of a full report from the OIG and by trying to focus media attention away from VA's response.

VA Failed to Address an Environment Known to Be Inhospitable to Women at the Washington DC VA Medical Center

The sexual assault alleged by the veteran drew attention to the medical center's long-standing reputation for having an inhospitable environment for women veterans. In his letter dated September 20, 2019, to the Secretary, Chairman Takano raised concerns about the environment at the medical center, noting that at least three individuals at the medical center who had interacted with the veteran did not take immediate action to intervene or assist her and that his staff has received reports that women veterans frequently experience sexual harassment and have been victims of sexual assault at VA medical facilities.⁹⁵ He requested, among other items, that VA conduct and require bystander intervention training, mandate reporting of incidents of sexual harassment at the medical center, and establish a Department-wide anti-harassment and anti-sexual assault policy so "[no] veteran, family member, caregiver, or VA employee [is] the victim of sexual assault or harassment at a VA facility."

⁹⁴ Secretary Wilkie has charged that the OIG's failure to provide a report was inconsistent with a statement on its website that "[f]or cases with substantiated allegations that are declined for prosecution, OIG reports its findings to VA management officials responsible for taking action to address the findings." In this case, the OIG made no finding with respect to whether the allegations were substantiated. Moreover, the OIG reported its concerns that might prompt a need for corrective action to VA during the investigation. Regardless, as discussed above, VA policy specifically provides that "primary responsibility" for investigating significant events "rests with the chief executive of the facility or staff office involved, and with their seniors in VA and its administrations." VA Directive 0700. The OIG is specifically excluded from this policy.

⁹⁵ Letter from HVAC Chairman Mark Takano to VA Secretary Robert Wilkie, September 20, 2019.

This section focuses on the following determinations:

- VA officials were aware that harassment at the medical center has been a persistent problem.
- The medical center director informally addressed concerns with the handling of the initial complaint about the sexual assault incident with staff at the medical center.
- The medical center did not implement the nationwide campaign to address harassment described in Secretary Wilkie's letter to Chairman Takano.

VA Leaders Knew that Women Veterans Experienced Harassment at the Medical Center

In her testimony, Ms. Powers described the medical center as “one of our hospitals that has challenges.” She said that previously, before she started at VA, she understood that there had been a “gauntlet” at the medical center, particularly near the entrance, and “there might have been some cat calls.” Ms. Powers told OIG investigators that conditions in the medical center have improved and that it is no longer a “gauntlet.” However, she could not provide any examples of specific improvements that had been made.

Acting General Counsel Hudson testified that following the January 2020 conclusion of the OIG-USAO investigation he wanted to investigate “what else we need to do in terms of fixing the gauntlet—having been in that D.C. Center, . . . I saw for myself that it is very distressful for anyone and especially females to go through that and be gawked and stared at.” He said that was one of the reasons they had a separate entrance for women to the pro bono legal assistance clinic. This testimony echoes statements of female veterans reported in media articles about the Washington DC VA Medical Center, though this serious issue is not unique to this medical center.⁹⁶

Indeed, in 2017, VA launched a national campaign to end harassment of female veterans at VA medical facilities. VA's website associated with the campaign indicates that posters and training were to be disseminated to every VA facility. The website references a 2015 study of 12 VA medical centers finding that one in four women veterans face inappropriate or unwanted comments or behaviors, including catcalls, stares, and sexual or derogatory comments. As acknowledged by the medical center director in OIG testimony and in his comments to medical center employees shortly after the veteran reported the incident, despite efforts to improve, medical center staff fell short of expectations in their handling of the veteran's sexual assault report in this instance.

⁹⁶ Abbie Bennett, “VA Leader Says Sexual Harassment Is Not ‘Pervasive’ at VA. These Veterans Disagree.” *Connecting Vets*, August 7, 2020; Victoria Chamberlain, “After Alleged Sexual Assault, Veterans Say Officials Aren't Doing Enough to Make The D.C. VA Safe For Women,” *WAMU*, January 17, 2020.

The Medical Center Director Informally Addressed Concerns about Staff's Handling of the Incident

Chairman Takano's letter noted that witnesses and three medical center staff with whom the veteran interacted did not immediately act to assist or intervene. The medical center director acknowledged that "the organization could have responded better in how [it] manage[s] a veteran who reports an allegation." To address this issue, he sent an all-employee email on September 26, 2019, calling out his dissatisfaction that "in the course of attempting to report this assault, the Veteran came into contact with several staff who referred her to other areas of the Medical Center. . . . I expect each of you to know how to report incidents of harassment or assault and to ensure a staff member, Veteran, or visitor is cared for and escorted to police services to file a report." Other emails reflect that he and the associate director engaged with the chief of the Patient Advocacy and Experience Office to stress the importance of contacting police whenever someone reports being sexually assaulted. The chief of the patient advocate office responded, "This has not been the first report of harassment that has happened and it has never been handled correctly. I have reported that to the [medical center's executive leadership team] in the past." Email evidence indicates that he had a follow-up discussion with the medical center director regarding his concerns.

VA Has Not Followed Through on Promises to Take Steps to Ensure Women Veterans Feel Safe and Welcomed at the Medical Center

In his October 16 response to Chairman Takano's September letter (figure 4), Secretary Wilkie outlined VA efforts to end harassment and intervene if harassment occurs.⁹⁷

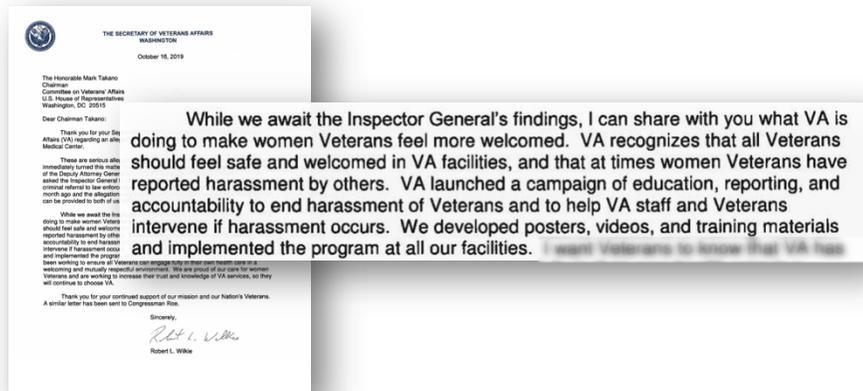


Figure 4. Letter dated October 16, 2019, from Secretary Wilkie to Chairman Takano, addressing VA's response to the veteran's allegations.

Source: VA.

⁹⁷ Letter from VA Secretary Robert Wilkie to HVAC Chairman Mark Takano, October 16, 2019.

According to Secretary Wilkie's letter, VA launched a campaign of "education, reporting, and accountability to end harassment of Veterans and to help VA staff and Veterans intervene if harassment occurs." Despite the letter's contention that VA had developed training materials and implemented the program at all facilities, the OIG investigation revealed that VA had not yet developed bystander training and had failed to ensure that all aspects of the anti-harassment campaign promised in the Secretary's letter were carried out at the medical center.⁹⁸

The Stand Up to Stop Harassment Now! campaign was kicked off in October 2019. The campaign includes a declaration by leaders of individual medical centers intended to publicly reaffirm VA's commitment to creating a safe, respectful, and welcoming healthcare environment for everyone and to encourage the reporting of incidents of harassment when they occur. As part of this campaign, the VHA office of communications disseminated a 23-page "toolkit" to all medical center public affairs officers, medical center directors, and Veterans Integrated Service Network (VISN) directors. The cover email instructed that as a follow-up to prior notices,

Over the next month, each medical center across the country will host local "Stand Up to Stop Harassment Now!" events that will include walking tours, focus groups and a declaration signing on Wednesday, October 30, 2019. The public declaration signing reaffirms our commitment to creating a safe, respectful and welcoming environment for everyone and encourages the reporting of incidents of harassment when they occur. The walking tours and focus groups will provide an opportunity for Veterans and employees to share their experiences, perspectives and concerns with medical center leadership, which will enable a better understanding of Veteran experiences and inform improvement strategies.

While some other medical centers appear to have rolled out the campaign, the Washington DC VA Medical Center has failed to implement key aspects of the program. The medical center director told OIG investigators that he signed the declaration, but that he did not do so until "some time after" the October 30, 2019, commitment date. On December 20, 2019, VHA Deputy Chief of Staff Jon Jensen emailed VHA Chief of Staff Larry Connell and Deputy Under Secretary for Health for Operations and Management Renee Oshinski concerning problems he observed with communications between the medical center and VISN 5.⁹⁹ Mr. Jensen reported, "I was also just informed that they didn't know about or do the Stop harassment now declaration signing or the qualitative walking tour. Of all places DC!"

The medical center director stated in his interview that he believed he had in fact signed the declaration prior to Mr. Jensen's December 20th email, and he was unsure of the basis for

⁹⁸ Unlike the administrative investigation into questions surrounding the contractor's conduct, there was no need for VA to await the conclusion of the joint OIG-USAO investigation before embarking on efforts to improve conditions at the medical center.

⁹⁹ Titles reflect the positions held by these individuals at that time.

Mr. Jensen's message. However, a December 23, 2019, email thread between the medical center director and VISN 5 officials reflects that arrangements were being made for the medical center director to "sign the declaration and send [a VISN 5 official] a cell phone photo of the image" to be forwarded to central office officials. In addition, an email dated January 29, 2020, between VHA officials discussing allegations of a separate inpatient sexual assault at the medical center included a VHA official noting that, as of that date, the medical center had "not yet held [the] October 2019 Stand Up to Stop Harassment public event."

The medical center director acknowledged that the public events contemplated by the initiative had not occurred, and stated that by February the medical center was "so far behind the curve" with implementation that the decision was made to wait until April in order to coincide with the "White Ribbon VA" campaign, a month-long national call to action to prevent and eliminate sexual harassment and domestic violence.¹⁰⁰ The emergence of the COVID-19 pandemic disrupted the planned rollout, which instead began on October 1, 2020, with an email announcement from VHA Executive in Charge Dr. Richard Stone inviting all VHA staff to wear a white ribbon for the month of October to "foster conversations" about domestic violence and sexual harassment. The campaign also includes a less than 20-minute training video about the White Ribbon VA commitment to never excuse or stay silent about sexual harassment, sexual assault, or domestic violence against others.

In addition to the public relations campaign, Secretary Wilkie's letter referenced training materials that were part of the program. In his letter dated September 20, 2019, Chairman Takano specifically requested that VA conduct and mandate bystander training at the medical center.¹⁰¹ Yet, Ms. Powers testified on July 22, 2020, during remarks before the House Veterans' Affairs Committee on Oversight and Investigations, that "the contract [to provide bystander training] kicked off in July [2020]" nationwide.¹⁰² She stated that, when implemented, the bystander training "is going to be for our veterans and our staff to identify what harassment looks like and to prevent it and to stop it."

Beyond the statements made to OIG investigators and those in the media about ongoing harassment at the medical center, there was evidence that some efforts undertaken by the medical center were made in recognition of the ongoing problem. For example, the facility released Facebook posts in June and July 2018 about harassment not being tolerated, with examples of inappropriate comments and actions, and the phone numbers to call for making reports to police or other staff. Although not specific to sexual harassment, the OIG also identified efforts to

¹⁰⁰ The medical center director confirmed that as of September 2020, the facility had not held the public events called for by the Stand Up to Stop Harassment Now! campaign.

¹⁰¹ Letter from HVAC Chairman Mark Takano to VA Secretary Robert Wilkie, September 20, 2019.

¹⁰² Pamela Powers, Testimony before the House Subcommittee on Oversight and Investigations.

address related concepts of respect and civility evidenced in townhall materials from October 2019 and June 2019 trainings mandated by the medical center director.

Finding 5 Conclusion

VA leaders failed to explore information available in the VA police file and in the medical center director's and associate director's files. That information, including the handling of a prior sexual harassment complaint against the same contractor, is relevant to whether VA determines any additional administrative action should be taken. The concerns of Secretary Wilkie and Ms. Powers about how VA might be criticized for following up on the incident did not justify inaction. Any argument that no action could be taken without more information from the OIG is without merit.

In October 2020, after following up on the information available to VA, the OIG informed the medical center director that the contractor may lack the appropriate credentials and background investigation required for routine physical access to the medical center, which is particularly concerning given the individual's criminal history. The medical center director responded with an action plan to address the issue prior to allowing the contractor to return to the facility when his service reopens after the COVID-19 pandemic has subsided. Given this resolution, the OIG will track and follow up on this proposed action but will not issue an additional recommendation in this report.

On a broader scale, despite the known issues around harassment at the medical center, VA failed to ensure that the national campaign was carried out at the Washington DC VA Medical Center. VA also has yet to take other measures requested by Chairman Takano, including mandating bystander intervention training, which can be offered online. This lack of urgency to change conditions at the medical center belies VA's stated commitment to creating a safe, respectful, and welcoming environment for everyone articulated in its Stand Up to Stop Harassment Now! campaign. VA's lack of action, paired with public statements about the veteran who made the sexual assault complaint, also seems contrary to its stated goal to encourage veterans and employees to report incidents of harassment.

Conclusion

The OIG cannot substantiate that Secretary Wilkie investigated or caused others to investigate the background of a veteran who raised sexual assault allegations.

OIG investigators did receive, however, substantial sworn testimony from senior VA officials that in small group meetings among VA officials, Secretary Wilkie and others referred to the veteran in denigrating terms, openly questioned her credibility, and reportedly ascribed a political motive to her reporting of the incident. The tone set by Secretary Wilkie appears to have influenced aspects of the initial VA police investigation and the conduct of other VA employees. This included an attempt by Deputy Assistant Secretary for Public Affairs Curtis Cashour to publicly discredit the veteran by contacting a journalist associated with a global media outlet and suggesting that the journalist look into the veteran's past. He stated he took this action based on a comment made to him by Secretary Wilkie, although he was not directed to do so.

Although VA took corrective action to address physical security issues including at least one inoperable camera at the medical center, the OIG determined that VA officials did not make serious attempts at examining the need for administrative action with respect to personnel issues brought to their attention. In discussions with Secretary Wilkie and then Deputy Secretary James Byrne in January 2020, Inspector General Missal responded to their questions about the need for any employee accountability measures by making clear that VA could consult any available information and make any additional inquiries necessary to make the determination. Basic reviews of the subject's criminal history and records of prior complaints kept within the medical center would have been sufficient to inform a decision about the extent of any necessary administrative follow-up efforts. No such review occurred. On October 1, 2020, as part of this administrative investigation, the OIG alerted the medical center director as to deficiencies in credentialing for the contractor. Contrary to stated goals and promises related to the anti-harassment initiative, the OIG also found that there was no serious effort by VA central office officials to ensure full participation by the Washington DC VA Medical Center—an environment repeatedly reported as inhospitable to women veterans.

For the reasons stated in each finding, this report makes no formal recommendations. Nonetheless conduct and inaction by VA leaders of the sort described in this report can impair the effectiveness and integrity of VA programs and operations. Effectiveness is undermined when veterans and the public do not perceive VA as being committed to ensuring a safe and welcoming environment.

Using denigrating remarks and questioning the credibility of a veteran who reported being sexually assaulted, and then failing to fully explore the facts, is also contrary to the ongoing missions of improving VA and of serving the veteran community with respect. VA personnel at every level are encouraged to commit to the highest standards of professionalism and

responsiveness when informed of allegations of sexual harassment or assault and to take all appropriate steps to dismantle inhospitable conditions in all VA medical facilities.

In response to this report, Secretary Wilkie provided written comments, which are published in their entirety as appendix B followed by the OIG's reply.

Appendix A: Scope and Methodology

Scope

The OIG's review period extended from September 20, 2019, the date of the veteran's complaint, through October 27, 2020.

Methodology

To accomplish its objectives, OIG investigators reviewed applicable laws (including criminal and civil statutes regarding obstruction of justice, witness tampering, destruction or alteration of records in a federal investigation, the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act), regulations, policies, procedures, and guidelines. OIG investigators interviewed 65 individuals, some more than once. Among those interviewed were Secretary Wilkie; Principal Deputy General Counsel, Performing the Delegable Duties of the General Counsel, William Hudson Jr.; Assistant Secretary for Public and Intergovernmental Affairs James Hutton; Chief of Staff, Performing the Delegable Duties of the Deputy Secretary Pamela Powers; Assistant Secretary for the Office of Congressional and Legislative Affairs, Performing the Delegable Duties of the Chief of Staff, Brooks Tucker; Deputy Assistant Secretary for Public Affairs Curtis Cashour; members of the VA police department and VHA security office; other current and former VA employees; and individuals outside VA with relevant knowledge.

The OIG also interviewed former VA Deputy Secretary James Byrne informally via telephone. Mr. Byrne declined to voluntarily appear before OIG investigators for a formal interview, and the OIG lacks testimonial subpoena power to compel the testimony of non-VA employees. Mr. Byrne nonetheless attested to his voluntary statements to the OIG.

Additionally, the OIG used a software application to analyze over 1.48 million documents, including relevant individuals' emails, media coverage regarding the veteran's allegations, public statements by VA and Secretary Wilkie about the veteran's allegations, and phone records received in response to OIG subpoenas.

In this report, the OIG removed identifiers for individuals where appropriate to protect their privacy interests.

Scope Limitations

The OIG based its conclusions on available evidence. In all, there were eight individuals who declined to be interviewed or re-interviewed by the OIG. Refusal to participate in follow-up interviews limited, in some instances, the OIG team's ability to reconcile conflicting testimony.

VA Witnesses' Refusals to Participate in Follow-Up Interviews

The OIG's investigation was limited by witnesses who declined to fully cooperate in four instances—specifically for follow-up interviews. These individuals are Secretary Wilkie, Ms. Powers, Mr. Hutton, and Mr. Cashour.

Other Witnesses' Refusals to Any Interviews

The OIG was unable to interview Congressman Daniel Crenshaw, Congressman Crenshaw's communications director, or the journalist with whom Mr. Cashour spoke. Each of them declined to speak with OIG investigators. Attempts to interview a former chief of staff to the Secretary of Defense made by telephone, personal email, and business email were also unsuccessful, and messages from investigators were not returned.

Unavailable Data

The OIG sought to determine whether any VA personnel accessed the veteran's health records for an unauthorized purpose during the criminal investigation into the veteran's allegations (September 20, 2019, to January 14, 2020). Data limitations prevented the OIG from reaching a conclusive finding as to this question.

VA maintains three applications that provide authorized users with access to veteran health records stored in the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record system.¹⁰³ Depending on the business need and level of access granted, authorized employees in the Veterans Health Administration, Veterans Benefits Administration, and other VA components with a need to access a veteran's health information in VistA may do so through one or more of these applications. The level of access granted to users depends on job function, need to know, and the level of security placed on certain sensitive patient records.

Audit logs were available for two of the three applications. Based on an analysis of the available audit logs, the OIG concluded that each of the VA employees identified as having accessed the veteran's records during the relevant time period were either processing benefits claims for the veteran or providing medical services to the veteran at the time of access, and therefore had a legitimate purpose for accessing the records.¹⁰⁴

A veteran's electronic health record is also accessible via the Computerized Patient Record System (CPRS). CPRS is primarily used by clinicians to manage patient care and records, but may also be accessed by managers, support staff, researchers, and others. CPRS contains no

¹⁰³ The three applications are Compensation & Pension Record Interchange (CAPRI), Joint Legacy Viewer (JLV), and Computerized Patient Record System (CPRS).

¹⁰⁴ Two other applications, the Veterans Benefits Management System (VBMS) and the Share system, are used by VBA for benefits processing. These systems also contain health information. The OIG reviewed the audit logs for Share and VBMS and concluded that no unauthorized access occurred.

audit trail with respect to this veteran's health records, and therefore the OIG is unable to determine whether anyone obtained (or attempted to obtain) unauthorized access.

As mentioned in the text, authorized VA personnel have access to the Defense Personnel Records Information Retrieval System (DPRIS) for DoD personnel files. Upon request by OIG investigators, the DoD DPRIS administrator found no evidence that anyone accessed the veteran's personnel record from September 20, 2019, to February 7, 2020 (the date Chairman Takano requested this investigation). The inspector general consulted with the DoD inspector general and learned that decentralized filing systems made it difficult to identify where all records potentially relating to prior complaints made by the veteran would exist, if any complaints were indeed made. It was also unclear whether all systems had auditable access logs. The OIG received sworn testimony from the veteran indicating that she had made a single complaint relating to a matter involving someone in her command while serving active duty, and that the complaint resulted in disciplinary action for a fellow servicemember. The OIG did not obtain sufficiently reliable and specific testimony from other witnesses indicating an effort by any VA personnel to gather records from the DoD. Therefore, investigators lacked information sufficient to make requests for records from any other particular DoD system. This scope limitation was also informed by principles guiding the treatment of crime victims, including the "right to be treated with fairness and with respect for the victim's dignity and privacy."¹⁰⁵

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Investigations*.

¹⁰⁵ 18 U.S.C. § 3771 (a)(8).

Appendix B: Management Comments and OIG Response

Date: December 7, 2020
From: Secretary Robert Wilkie
Subj: Administrative Investigation
To: Inspector General Michael Missal

After nearly a year of investigation, interviews with 65 people and analysis of nearly 1.5 million documents, VA's inspector general cannot substantiate that I sought to investigate or asked others to investigate the Veteran. That's because these allegations are false.

What's more, the IG could not identify a single instance in which any VA employee violated any rule, regulation or policy. If it had, it would have issued recommendations, which it did not.

Unlike all current VA senior leaders who were asked, the dismissed former senior leader – who was a main proponent of the false allegations that served as a basis for this investigation – declined to appear before the IG for a formal interview. What's more, the IG “did not identify any documentary evidence corroborating his statements.” And after interviewing 65 people, investigators could not identify anyone who could corroborate the former senior leader's account.

Having failed to prove the false allegations that served as the basis for this investigation, the IG shifted its focus to policing and critiquing confidential internal deliberations among VA staff. In doing so, the IG established a strawman in which any discussion or scrutiny of public and high-profile allegations against the department, or a general desire to know the truth are somehow improper. This is an impossible standard that no organization – including the inspector general – could meet. And if any organization had its confidential internal deliberations cherry-picked and packaged into a public report, the result would no doubt be similar to this one.

VA takes all allegations of sexual assault seriously, which is why I immediately reported the original 2019 Washington DC VA Medical Center complaint to VA's independent inspector general as well as the deputy attorney general.

But the tortuous logic the IG uses in an attempt to justify the abdication of its responsibility to provide the department with a report into that complaint is extremely bewildering and contrary to IG policy, which states: “For cases with substantiated allegations that are declined for prosecution, OIG reports its findings to VA management officials responsible for taking action to address the findings.” Rather than providing an official report of any findings and/or

wrongdoing, the IG's position is that VA should have mounted its own secondary investigation into the 2019 complaint.

In other words, the IG is criticizing VA for not doing the very same thing it has spent months investigating. Such faulty rationale is not the product of a serious investigation. In fact, it's indicative of one that has become more dedicated to scoring political points than improving the department – a dynamic that has defined the IG's conduct throughout this investigation.

(Original signed by:)

Robert L. Wilkie

OIG Response

Secretary Wilkie's comments on this report do not respond substantively to its findings. Instead they mischaracterize key facts and fail to acknowledge the deficiencies in VA's response to the veteran's complaint. Notably, his comments do not seek to correct or supplement the findings.

The Secretary's comments accurately note that the OIG could not conclusively sustain or refute whether he or others investigated the veteran. His remarks do not, however, address the troubling conduct detailed in the report's other four findings. For example, six senior officials testified they heard the Secretary state that the veteran who filed the sexual assault complaint had done something like this before (or words to that effect)—implying her complaints were unfounded. The Secretary's comments ignore that denigrating and discrediting remarks have an impact on VA officials' responses. Most visibly, a VA public affairs official attempted to convince a journalist for a global media outlet to investigate whether the veteran was a serial complainer.

The Secretary's assertion that he could not act in the absence of "an official report of any findings" from the OIG is simply wrong. The Secretary persists in incorrectly characterizing an inapplicable website FAQ about OIG's investigative process as a "policy" to support his demand for a formal report. Neither the OIG nor the Department of Justice releases criminal investigation reports as a matter of course. Despite receiving other oral and written communications from the OIG with information needed to make an informed decision about whether follow-up action was appropriate, the Secretary did not act. He testified that an inquiry was not conducted because he feared further criticism about investigating the veteran. This overlooks that VA can adequately evaluate the relevant medical center security issues without seeking any information from (or about) the veteran.

Moreover, as it routinely does, the OIG reported to VA information related to pertinent safety issues. When the OIG reports facts sufficient to raise a potential safety concern, VA has a duty to act. VA officials had the information needed to conduct meaningful follow-up action regarding the individual the veteran accused and to advance VA's efforts to make the medical center more hospitable to women.

There were a number of other inaccurate assertions made in the Secretary's comments, including that the OIG's work was influenced by partisan politics. As an independent oversight authority, the OIG's administrative reports have examined the conduct of both Democratic and Republican administrations. This report properly scrutinizes responses by the Secretary and other senior officials to a veteran's sexual assault complaint that were inconsistent with VA's guiding principles for professionalism, treating all veterans with respect, and creating safe and welcoming spaces. To suggest otherwise attempts to distract from VA's missteps in responding to the initial complaint, the mischaracterization of the criminal investigation, and failure to take appropriate action.

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