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BEFORE THE
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EXAMINING THE DEPARTMENT OF VETERANS AFFAIRS POLICE PROGRAM
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Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the Department of Veterans Affairs (VA) security and law enforcement program (police program). The OIG is committed to serving veterans and the public by conducting oversight of VA programs and operations through independent audits, inspections, reviews, and investigations. That oversight is particularly compelling when the safety of VA personnel, veterans and their families, and visitors to VA facilities are at issue. How VA police providing those protective and law enforcement services are guided, managed, and supported certainly warrants close scrutiny.

The Office of Security and Law Enforcement's (OS&LE) Police Service group has different divisions responsible for such functions as public safety, investigations, infrastructure protection, executive protection, and police unit inspections. My statement focuses on the policing duties carried out primarily in VA medical facilities, particularly the effectiveness of the police program governance structure and the challenges VA has faced in staffing and overseeing its police workforce. I would like to highlight the findings from a December 2018 OIG report, *Inadequate Governance of the VA Police Program at Medical Facilities* and our most recent staffing report.[1] I would also like to note that the OIG subsequently published a report on *Mismanagement of the VA Executive Protection Division* in 2019, which falls within the Police Service group.[2] That report found that VA failed to develop adequate threat assessments and written policies, which contributed to security vulnerabilities. Common challenges identified in these and other OIG reports such as staffing shortages, the splintering of oversight responsibilities, confusion about roles, and lack of clear guidance can undermine VA's well-intentioned goals and objectives.

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[1] *Inadequate Governance of the VA Police Program at Medical Facilities*, December 13, 2018, and *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, June 14, 2018.

[2] *Mismanagement of the VA Executive Protection Division*, January 17, 2019.

BACKGROUND

VA's Veterans Health Administration (VHA) provides health care to over 6 million veterans in its medical facilities. Federal law provides the VA Secretary with the authority and responsibility to protect patients, visitors, employees, and VA property.[3] VA police officers provide security and law enforcement services at VHA facilities, as well as Veterans Benefits Administration offices collocated with VHA facilities, and some VA national cemeteries. They are authorized to carry firearms in an official capacity, investigate criminal activity, and arrest individuals on department property for offenses committed within VA's jurisdiction and consistent with other law enforcement agency agreements.[4] VA's police force consists of approximately 4,000 officers, at 139 of 141 VA medical facilities, which places it among the 10 largest law enforcement workforces in the federal government. Other federal agencies provide security at the remaining VA healthcare facilities, such as the Manilla Outpatient Clinic.

Responsibility for the police program is splintered between VHA and the VA Office of Operations, Security, and Preparedness (OSP). In addition, on September 14, 2018, VA Secretary Wilkie reassigned OSP to the Assistant Secretary for Human Resources and Administration and the position of Assistant Secretary for OSP was eliminated.

VHA has historically had primary responsibility for the police program, including ensuring VA police officers were qualified and maintained physical security on agency property.[5] VA policy designated the Deputy Under Secretary for Health for Operations and Management (DUSHOM) as the senior VHA official (together with Veterans Integrated Service Network (VISN) directors) for ensuring police program requirements are achieved, such as maintaining enough officers on duty with proper equipment and supervision.[6] Each of the 18 VISNs have designated a VISN police chief who provides technical guidance and assistance to their respective network medical facilities. Primary responsibility for operations, however, falls to the local VA police chiefs who report to their medical facility directors, who in turn are responsible for verifying police officers' qualifications, ensuring law enforcement activities are accomplished, and maintaining enough officers on duty at the facility to protect people and property.

OSP is a VA staff office that provides limited department-level program oversight of VA's security and law enforcement activities. Aligned under OSP, the OS&LE is responsible for developing and issuing national police program policies, protecting the VA Secretary and Deputy Secretary, investigating potential criminal incidents at VA facilities, and conducting inspections of medical facility police units to determine if program requirements are being met. Police inspections provide a check on the adequate implementation of critical program

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[3] Title 38, United States Code, § 901, Authority to prescribe rules for conduct and penalties for violations.

[4] Title 38, United States Code, § 902, Enforcement and arrest authority of Department police officers.

[5] Department of Medicine and Surgery Supplement MP-1, Part 1, Change 42, Chapter 2, Investigation, Security and Law Enforcement Policy, paragraph 11a (2) and 13d (1), July 23, 1986.

[6] VA Directive 0730, Security and Law Enforcement, paragraph 3g, December 12, 2012.

operations such as physical security, rapid response activities, police staffing, and investigative activities. They are also meant to identify any corrective actions needed. The police inspections include assessments of risks to patients, visitors, and employees.

VA GOVERNANCE OVER THE POLICE PROGRAM WAS INADEQUATE FOR CONDUCTING EFFECTIVE OVERSIGHT

The OIG received complaints through the its Hotline related to the accountability and performance of some VA police officers at medical facilities. The OIG recognized the importance of examining how oversight of VA police performance is conducted at a system-wide level. The focus of the audit was to determine whether the VA police program has an effective governance structure in place, meets requirements for size and qualifications, and conducts adequate inspections to ensure compliance with policies and procedures.

The OIG determined that VA did not have adequate and coordinated governance over its police program to ensure effective management and oversight for its police officer workforce at its medical facilities nationwide. The OIG found that the governance problems occurred and persisted, in part, because of confusion about police program roles and authority between VHA and OS&LE. The DUSHOM told the audit team that OS&LE was responsible for centrally managing police program activities at VHA facilities. However, OS&LE did not have that responsibility and did not have authority, for example, to manage funding and pay decisions for VA police, to hold medical facilities accountable for adhering to police program policies, or to require staff within VHA to help perform timely inspections of medical facilities. Governance issues also stemmed from a lack of a centralized management or clearly designated staff within VHA to manage and oversee the police program. Because the assignment of OSP to VA's Human Resources and Administration Assistant Secretary was made after the audit work was conducted, that office's oversight role in this mix was not evaluated.

The OIG audit revealed four key areas of concern:

- Systemic tracking and assessment of police program operations and performance by VHA and OS&LE
- Facility-appropriate police officer staffing models and officer shortages at VA medical facilities
- Timeliness of inspections of police operations at VA medical facilities
- Guidance on how VA police officers investigate the alleged misconduct of facility leaders who manage the police program or control its resources

VHA and OS&LE Did Not Track and Assess Police Program Operations and Performance in a Systemic and Effective Manner

The OIG determined that the Office of the DUSHOM lacked mechanisms to systematically track and assess police program operations and performance at medical facilities, such as whether facilities maintained sufficient numbers of police officers to protect patients, visitors, and employees. The DUSHOM told the OIG that he had been unaware of trends or patterns occurring

within the police program at VA medical facilities. His office also did not track and assess VA police workload indicators system-wide, including the number and type of arrests, traffic violations, and investigative activities. In February 2018, he said that he had not received the results of OS&LE's inspection activities for FY 2017. He also reported not having received any inspection results for FY 2018, except for facilities whose police programs were rated marginally satisfactory or unsatisfactory by OS&LE. Similarly, OS&LE did not prepare trend analyses or assessments of its inspection results and recommendations on police program performance at medical facilities.

VA Lacked Facility-Appropriate Police Officer Staffing Models and Had Extensive Shortages of VA Police Officers

The OIG found that VA could not have confidence that facilities maintained sufficient numbers of police officers to provide security and protection services given oversight system deficiencies. VHA lacked police officer staffing models that could be tailored to the needs of similar types of medical facilities to determine the appropriate number and composition of police officers. The OIG also found that many medical facilities were below their individual authorized levels of police officers. According to information provided from the Office of the DUSHOM for the OIG audit, VHA reported 4,881 police officer positions were authorized as of January 31, 2018, but 875 positions (18 percent) were vacant or in the process of being filled. Fifty-six of the 139 medical facilities with VA police operations (40 percent) reported officer vacancy rates of 20 percent or higher. Concerns about policing shortages in the audit are consistent with the OIG's staffing report released in June 2019, which examines medical facility directors' self-reported clinical and nonclinical staffing shortages. With regard to nonclinical shortages, police were the second highest reported nonclinical staffing need.[7]

VA medical facility staff at five sites that the OIG visited noted several factors contributing to recruitment and retention challenges, including problems obtaining local facility approval to hire police officers due to changes in facility management.[8] In addition, VA police salaries were not competitive with other local and federal agencies and there were competing priorities in hiring healthcare staff. The OIG determined that four of the five medical facilities visited had over 20 percent vacancy rates. The medical facilities did not fully use staffing strategies such as recruitment planning or the use of special salary rates or incentives.

The OIG found that the lack of facility-appropriate police staffing models and insufficient police coverage at VA medical facilities can affect security activities. VA medical facilities with insufficient numbers of police officers had to borrow officers from other facilities and use

[7] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, June 14, 2018.

[8] The OIG selected five VA medical facilities for on-site review in North Little Rock, Arkansas; Denver, Colorado; Washington, DC; Albany, New York; and Columbia, South Carolina.

overtime pay to augment staffing levels to ensure adequate coverage.[9] For example, the Hampton, Virginia, VA Medical Center (VAMC) borrowed 23 police officers from nine other medical facilities to work at the VAMC from December 2017 through April 2018, based on facility records. A shortage of police officers at the VAMC had been a concern since at least June 2017, when nine of 23 authorized police officer position were vacant.

OS&LE Did Not Conduct Timely Inspections of VA Police Operations

The OIG determined that as of September 30, 2017, OS&LE did not timely inspect 103 of the 139 VA medical facilities with police units (74 percent). OS&LE written procedures required its staff to inspect VA medical facility police units on a two-year cycle. On November 7, 2014, OS&LE changed that inspection process to require inspections of medical facility police units on a four-year cycle. OS&LE updated its own internal process on that same day to include an expectation that VISN police chiefs would perform midcycle (two-year) inspections. However, most VISN police chiefs did not start this process, and OS&LE did not receive any inspection reports in FY 2017 as expected.[10]

Based on the number and type of deficiencies identified in the inspection, OS&LE assigns police units an overall rating of outstanding, highly satisfactory, satisfactory, marginally satisfactory, or unsatisfactory. OS&LE written procedures require its staff to reinspect VA medical facility police units within one year for a marginally satisfactory rating and within 90 or 180 days for an unsatisfactory rating (depending on the governing policy in place at that time).

The OIG found that of the 103 VA medical facility police units not inspected within prescribed time periods

- 95 VA medical facility police units had overdue cyclical inspections by an average of 286 days, or about 10 months, over the two-year inspection cycle;
- Four VA medical facility police units previously rated as marginally satisfactory were not reinspected within one year (with the average for these untimely reinspections at 345 days, or close to 12 months, beyond the one-year reinspection requirement); and
- Four VA medical facility police units previously rated as unsatisfactory were not reinspected within the applicable 90- or 180-day reinspection requirement (with the average for these reinspections at 162 days, or just over five months beyond the applicable timeline).

The OIG determined that these delays were attributed to OS&LE having limited staff available for inspections. Since 2014, OS&LE had six employees in its inspection division to inspect medical facility police units along with other divisional duties. There were only three employees

[9] According to the VHA Chief Financial Officer, VHA facilities spent approximately $26.6 million in fiscal year (FY) 2017 on overtime pay for its police services.

[10] On April 14, 2018, OS&LE reverted to requiring its own staff to inspect VA medical facility police units on a two-year cycle.

available for inspections by the end of FY 2017 (that is, September 2017) because the other three employees were reassigned within OS&LE to assist with the protection of the then VA Secretary and Deputy Secretary. Having overdue inspections of medical facility police units limits VA's ability to know whether programs or police officers are performing adequately, and whether previously identified deficiencies are corrected. VA has taken important steps in this area. OSP requested 10 additional employees for FY 2019 to support OS&LE operations including inspections of medical facility police units. As of April 2019, OSP reported that nine employees were hired with seven of them solely focused on performing police inspections.

VA Officers Lacked Guidance on Investigating Facility Leaders Who Manage Their Program or Control Its Resources

Under the supervision of the medical facility director, VA police officers investigate reported crimes and misconduct, and the police chiefs brief and consult with the facility director on the status of all investigative activities to determine further investigative or referral actions. The OIG identified two instances in which VA police officers performed investigations into alleged misconduct of facility leaders who managed the police program or had control over program resources at their own medical facilities. These types of investigations occurred because VA did not have written guidance specifically for VA police on how to appropriately investigate misconduct allegations involving their local facility leaders, including coordination with other offices and documenting decisions.

RECOMMENDATIONS

The OIG made five recommendations to the VA Deputy Secretary that focused on the areas of governance, staffing, the inspection program, and processes.

1. Clarify program responsibilities between the Veterans Health Administration and the Office of Operations, Security, and Preparedness, and evaluate the need for a centralized management entity for the security and law enforcement program across all medical facilities.
2. Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.
3. Make certain medical facilities use strategies to address police staffing challenges such as having documented recruitment plans for police officer positions that include a determination of the need for special salary rates and incentives.
4. Assess the staffing levels for the Office of Security and Law Enforcement police inspection program and authorize and provide sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues.
5. Ensure procedures are developed for appropriately handling VA police investigations of medical facility leaders.

At the time the OIG report was published, the acting VA Deputy Secretary concurred with all recommendations and requested that recommendation five be closed. However, the OIG considered this recommendation to be open until written procedures were developed for VA police officers concerning how they should appropriately handle their investigations of medical facility leaders. As of April 2019, VA responded that it plans to have the Office of General Counsel and Office of Accountability and Whistleblower Protection coordinate to assist with language to be crafted for inclusion into the latest VA Handbook 0730. This will provide procedures for VA police to refer allegations against medical facility leadership to the proper investigative authority. Until the OIG receives documentation, that recommendation, and all others, remain open.

ONGOING WORK ON THE POLICE PROGRAM

From information gleaned from the police governance audit, the OIG learned that the information systems VA police use to make resource-allocation and other key management decisions have created obstacles to their work. Effective program governance relies on information management to respond to risks and achieve program objectives. Recognizing the critical link between these systems and monitoring capabilities, the OIG is currently conducting additional audit work on information management within the police program. This work will focus on whether the VA police program's information management strategy and systems provide its leaders and workforce with the information needed to manage and guide operational performance. The audit team will identify the causes of VA's challenges in transitioning to a new police information system and the impact on the operation and governance of the program.

CONCLUSION

Having an effective governance structure is critically important to the functioning of any program. The confusion about program roles and authority makes it difficult for VA to have any degree of certainty that its police personnel and resources are being effectively deployed. The safety of veterans, VA staff, and visitors to VA medical facilities is of paramount importance to VA. To achieve its goals for protecting those individuals and VA property, the governance structure, staffing issues, and proper program oversight processes must be addressed. At the center of those decisions are whether the governance structure should be more centralized and, if so, how that should be accomplished. That includes determining whether medical facility directors are best positioned to provide oversight of police functions and how information flows both up and down the various levels of VA to ensure that staffing, policies, practices, and oversight are effective.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.