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BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS POLICIES AND ACTIONS TO PREVENT SEXUAL ASSAULTS AND OTHER SAFETY INCIDENTS AT VA MEDICAL FACILITIES
ON JUNE 13, 2011

Madam Chairwoman and Members of the Subcommittee, thank you for the opportunity to discuss how the Office of Inspector General (OIG) interacts with the Department of Veterans Affairs (VA) with regards to reporting alleged felonies, including sexual assaults at VA medical facilities. I would also like to share some other work by the OIG in the area of safety at VA medical facilities.

BACKGROUND

The OIG's Office of Investigations conducts criminal and administrative investigations involving crimes impacting the Department's programs and operations and serious misconduct by senior management. When evidence of a crime or serious misconduct is developed during an investigation, we seek appropriate prosecution and/or administrative action to assist the VA in maintaining an environment that is safe for employees, patients, and visitors and protected against criminal activity.

VA maintains a police force at all VA Medical Centers (VAMCs) that has jurisdiction over alleged crimes that happen on VA property. In the last few years, the relationship between the OIG and VA Police has improved. The OIG requires all of our field supervisors to, whenever possible, identify a specific special agent to each VAMC Director, Pharmacy Chief, and Police Chief to serve as a primary liaison with that VAMC.

Additionally, in order to deter crime, criminal investigators continue to provide approximately 200 crime awareness briefings each fiscal year to about 13,000 employees at VA facilities nationwide. These briefings are intended to ensure that VA employees are aware of the many types of fraud and criminal activity that can victimize VA, VA employees, and veterans. These briefings have resulted in additional referrals of alleged criminal activity.

Finally, either the Assistant Inspector General for Investigations or I have addressed the VA Police Chiefs at their annual conference for the last 3 years. In each of these liaison efforts, we remind VA Police and other VA personnel of the requirement to report suspected felonies to the OIG. We emphasize that failure to provide timely notification may jeopardize our ability to successfully investigate an allegation. Recognizing our limited staffing and geographic footprint, we advise that we do not expect to be notified before local law enforcement but that we do expect to be notified in a timely manner. We provide nearly immediate feedback whether or not we will open an investigation.

The Code of Federal Regulations (CFR) require all VA employees to report suspected criminal behavior to VA management and/or the OIG.

- 38 CFR § 1.201 – Employee's duty to report – All VA employees with knowledge or information about actual or possible violations of criminal law related to VA programs, operations, facilities, contracts, or information technology systems shall immediately report such knowledge of information to their supervisor, any management official, or directly to the Office of Inspector General.

- 38 CFR § 1.204 – Information to be reported to the Office of Inspector General - Criminal matters involving felonies will also be immediately referred to the Office of Inspector General, Office of Investigations. VA management officials with information about possible criminal matters involving felonies will ensure and be responsible for prompt referrals to the OIG. Examples of felonies include but are not limited to, theft of Government property over $1000, false claims, false statements, drug offenses, crimes involving information technology systems and serious crimes against the person, i.e., homicides, armed robbery, rape, aggravated assault and serious physical abuse of a VA patient.

GOVERNMENT ACCOUNTABILITY OFFICE REVIEW

When the Government Accountability Office (GAO) contacted the OIG for information involving allegations of sexual assault, we provided detailed information and OIG investigative reports about 119 OIG investigations completed between January 2005 and June 2010 that involved allegations of sexual assault ranging from inappropriate touching to rape. Subsequently, GAO advised that the 2005 and 2006 data would not be used in their analysis; however, they requested an additional 6 weeks of 2010 data as well as any cases that were open during the previous search, but were now closed. We found information associated with 11 additional closed cases that we provided to GAO. We also provided GAO with de-identified information about nine sexual assault investigations that remained in an open status as of August 1, 2010.

Later, GAO requested that we review 42 scenarios regarding alleged sexual assaults that had occurred on VA property, but were not, according to GAO's research, referred by VA Police to the OIG. We had four senior agents review the information and they concluded the following:

- In 23 (55 percent) of the scenarios, we would not have expected VA Police to notify the OIG. Examples included allegations that lacked any evidence of sexual assault obtained as a result of a medical examination, to include a sexual assault collection kit that did not reveal signs of sexual assault, and a victim who quickly recanted the original allegation. Also included in this group were allegations of a rape by a "celestial being" and consensual sex engaged in by two inpatients.

- In 14 (33 percent) of the scenarios, we would have expected VA Police to notify the OIG. Examples included a victim with dirt and grass on her clothing and in her hair who reported that she had been raped while walking on the grounds of a VA Medical

Center, and a female physician who reported that a male patient sexually assaulted her while conducting an examination.

- In 5 (12 percent) of the scenarios, we could not make a judgment because of either ambiguous or inadequate information in the scenario description.

We also advised GAO that we recognized at least one scenario as an open case that had been originally reported to us by VA Police. Because GAO would not provide us any information that might identify the victim, accused subject, or facility associated with any of the 42 scenarios, we could not determine if there were other open cases that may have been reported to us.

The following examples illustrate cases originally reported to us by the VA Police that we worked jointly with them:

- A female veteran reported that a VA employee had made sexually inappropriate conversation and physical contact with her during several treatment sessions. The employee has been charged with attempted criminal sexual abuse and simple battery.

- A VA patient reported that a fellow inpatient at the VAMC sexually assaulted her on a number of occasions during her stay in a locked psychiatric unit. The suspect pled guilty to sexual assault in the 3rd degree and was sentenced to 1 year of incarceration and 3 years' probation.

- A VA patient residing in a VAMC assisted living area reported being sexually assaulted by his roommate, a convicted sex offender. The suspect was indicted on two counts of rape, two counts of sexual battery, and two counts of gross sexual imposition. He pled guilty to two counts of sexual battery and was sentenced to 6 months in county custody and 3 years of community controls by the county's sex offender unit. In addition, the judge classified him as a Tier III sex offender, and he will have to register his address in person every 90 days for life.

- A VA Chief Financial Officer sexually assaulted his minor daughter on numerous occasions in his apartment, which was located on VAMC property. This employee was recently sentenced to 36 months' incarceration. Our investigation also revealed that the defendant sexually assaulted the same daughter in a Las Vegas hotel. Subsequently, he was sentenced to a year's incarceration in Nevada.

While these examples demonstrate VA Police complying with the CFR reporting requirements, we are aware of instances of failure to timely report suspected felonies to the OIG. This decreases the likelihood of a successful resolution especially if VA Police have already conducted interviews and done other work. For example, after receiving a report from a female inpatient that 2 days earlier she had been raped, VA Police interviewed both the victim and the suspect, searched the vehicles of both the suspect and victim, took possession of the suspect's cell phone, and interviewed common acquaintances prior to contacting our local office, which is approximately 15 to 20

minutes from the VAMC. When OIG special agents joined the investigation, they added value by obtaining additional information from the victim and transporting her to a local hospital where she was examined by a Sexual Assault Response Team nurse. Additionally, when the OIG agents searched the suspect's vehicle, they discovered potential evidence, a used condom. Finally, had the victim not withdrawn her allegation and admitted to the consensual nature of the event, some evidence recovered prior to our involvement in the investigation may have been suppressed because the consent obtained to search the suspect's cell phone was verbal, not written.

We welcome GAO's recommendation to automate reminders to VA Police to notify the OIG when entering a felony offense into the VA Police database. We are pleased with the VA Police's intention to also implement an automated notice to our field offices whenever the record of such an offense is created. We believe both measures will greatly reduce the number of instances when we are not notified of alleged felonies.

OTHER OIG WORK

The OIG, in October 2008, issued an *Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy* (October 9, 2008) in which we assessed the effectiveness of safety, security, and privacy of veterans residing in VA domiciliaries. We found that the Veterans Health Administration needed to implement additional national procedures and clarify national guidance to ensure that safety, security, and privacy issues are sufficiently identified, reported, and corrected throughout the year. We reported on three issues that impacted all 49 domiciliaries:

- There is a need to establish national procedures for the inspections of veterans' room.
- Additional safety, security, and privacy procedures are needed for female veterans along with security initiatives for all veteran residents.
- Improvements are needed in annual safety, security, and privacy reporting as well as the follow-up process.

The report contained eight recommendations, which according to VA have all been implemented.

CONCLUSION

The OIG and the VA Police have enhanced our working relationship over the last several years in order to protect patients, visitors, and employees at VA medical facilities. It is a commitment that both organizations take seriously. The Director of VA's Law Enforcement and Security Office e-mailed me recently stating "As we all agree, we are one team of law enforcement professionals and I and my senior team believe in working together." We in the Office of Inspector General share that sentiment.

Madam Chairwoman, this concludes my statement and I would be happy to answer any questions that you or other members of the Subcommittee may have.