June 11, 2015

The Honorable Michael E. Horowitz  
Chair  
Council of the Inspectors General on Integrity and Efficiency  
1717 H Street, NW, Suite 825  
Washington, DC 20006

Mr. Joseph F. Campbell  
Chairman  
Integrity Committee  
Council of the Inspectors General on Integrity and Efficiency  
935 Pennsylvania Ave., NW  
Washington, DC 20535-0001

Dear Messrs. Horowitz and Campbell:

On June 3, 2015, the Committee on Homeland Security and Governmental Affairs held a hearing to examine vacancies in the inspector general (IG) community, during which the Committee discussed weaknesses associated with non-permanent, acting IGs.¹ In particular, the hearing identified numerous problems with the Department of Veterans Affairs Office of Inspector General (VA OIG), led by Deputy Inspector General Richard J. Griffin. Among other shortcomings, the Committee heard testimony about the VA OIG’s unnecessary, harassing, and potentially extralegal, or at the very least, highly inappropriate subpoena of a nonpartisan good-government watchdog, the Project on Government Oversight (POGO). I write to request that the Council of Inspectors General on Integrity and Efficiency (CIGIE) Integrity Committee examine the VA OIG’s potential abuse of power in this matter.

Deputy Inspector General Griffin has served as the head of the VA Office of Inspector General (OIG) since December 2013. His tenure as acting IG has been marked by a long list of failures that highlight the office’s lack of independence and transparency. In October 2014, news reports highlighted that VA officials influenced the VA OIG to downplay whistleblower claims that wait times contributed to veteran deaths in the Phoenix VA Health Care System.² VA Deputy Secretary, Sloan Gibson, even referred to VA Deputy Inspector General Griffin as “Griff,” suggesting an intimacy between the two that may compromise the ability of the OIG to

¹ “Watchdogs Needed: Top Government Investigator Positions Left Unfilled for Years”: Hearing before the S. Comm. on Homeland Sec. & Governmental Affairs, 114th Cong. (2015).
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dispassionately oversee the VA. The VA OIG also administratively closed a two-year healthcare inspection at the Tomah VA Medical Center and limited sharing the report and its findings with only one member and failed to make it public until news reports forced its disclosure. It is possible that because the VA OIG withheld its report from public view, veterans who were treated at the facility tragically died.

The VA OIG’s interactions with POGO are particularly alarming. Last year, POGO and the Iraq and Afghanistan Veterans of America (IAVA) established a website where VA employees can report waste, fraud, and abuse. Through the website, POGO received over 700 communications from individuals with knowledge of VA malfeasance and misfeasance. Some employees who contacted POGO through the website requested anonymity for fear of retaliation for their whistleblowing.

For reasons unknown, the VA OIG sought to obtain the identities of the VA whistleblowers in communication with POGO. In discussions with the Mr. Griffin’s Counsel, Maureen Regan, POGO offered to provide the VA OIG with the subject matter of the whistleblower complaints, but Ms. Regan refused to accept this information. On May 30, 2014, the VA OIG issued an administrative subpoena to POGO, requiring the group to turn over all records it collected relating to “wait times, access to care, and/or patient scheduling issues at the Phoenix, Arizona VA Healthcare System and any other VA medical facility.” To date, POGO has courageously refused to comply with the VA OIG’s extralegal administrative subpoena, citing its belief that the VA OIG’s subpoena is unconstitutional and that the subpoena will have a chilling effect on future whistleblowers.

I am puzzled by the VA OIG’s decision to issue an administrative subpoena to a nonpartisan good-government watchdog whose only goal was to assist veterans in improving the VA. During the Committee’s hearing, Inspector General Horowitz acknowledged the inappropriateness of the VA OIG subpoena, testifying that he would not “consider issuing a

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3 Id.
7 Id.
subpoena to any organization to look for information about whistleblowers.” 11 Likewise, Daniel Epstein, Executive Director of Cause of Action, testified that under the Inspector General Act, the VA OIG “does not have any authority to subpoena any outside entity that has no purpose for federal program administration.” 12

Other VA employees have expressed to other inspectors general that there is widespread mistrust of the VA OIG among VA employees. 13 Indeed, during the Committee’s investigation of the tragedies that occurred at the VA Medical Center in Tomah, Wisconsin, dozens of current and former employees at the facility have told my staff that they have no confidence in the VA OIG and have felt that VA employees have no recourse available to them to expose waste, fraud, and abuse. Tragically, the ineffectiveness and lack of confidence in the VA OIG allowed the widespread prescription of opiate drugs and a culture of fear to permeate at the facility for many years.

During the Committee’s hearing, I asked Mr. Horowitz whether CIGIE’s Integrity Committee had looked into the VA OIG’s subpoena of POGO. He testified that he was unaware of whether such an inquiry occurred. Accordingly, given the serious questions surrounding the VA OIG’s administrative subpoena to POGO and the overall mistrust in the VA OIG, I ask that the CIGIE Integrity Committee examine the actions of Richard J. Griffin, Maureen Regan, and the VA OIG. Our nation’s veterans deserve an effective and reasonable watchdog in the VA Office of Inspector General. I respectfully request a response to this request as soon as possible, but no later than 5:00 p.m. on June 25, 2015. Thank you for your prompt attention to this matter.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
    Ranking Member

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12 Id. (statement of Daniel Z. Epstein, Cause of Action).
13 Id. (prepared statement of Danielle Brian, Exec. Dir., Project on Gov’t Oversight).