THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

November 21, 2024

The Honorable Hampton Dellinger
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-24-000869

Dear Mr. Dellinger:

I am responding to your May 30, 2024, letter to the Department of Veterans Affairs (VA) regarding a whistleblower's allegations that officials at the VA Eastern Kansas Healthcare System, Dwight D. Eisenhower VA Medical Center (Eisenhower VAMC) in Leavenworth, Kansas violated VA Handbook 0720, section 3(e), when they did not properly restrict a VA Police Officer's access to the facility armory after being served with a protective order that prohibited possession of and access to firearms; and violated VA Handbook 0730, section 5(j), Security and Law Enforcement, because of dead zones in the radio system that caused the police radios not to function.

The Under Secretary for Health directed the Veterans Health Administration Office of the Senior Security Officer and the VA Office of Security and Law Enforcement to assemble and lead a VA team to conduct an investigation. VA conducted an onsite investigation prior to the receipt of the U.S. Office of Special Counsel disclosure. The investigation occurred from April 3, 2024, to May 13, 2024.

We substantiate the whistleblower's allegations. In response to the allegations, the four physical security deficiencies were corrected immediately; contracting and Eisenhower VAMC fiscal staff have confirmed that the radio improvement contract is funded and close to compliance with Fair Acquisition Regulations and other applicable contract award laws and policies; and an all-level organization-wide safety standdown was held from June 10, 2024, to June 14, 2024.

Thank you for the opportunity to respond. The enclosed report will be sent to the respective offices with a request for an action plan.

Sincerely,

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Denis McDonough

Enclosure

Department of Veterans Affairs (VA)

Report for the Office of Special Counsel

VA Eastern Kansas Health Care System

Dwight D. Eisenhower VA Medical Center

Leavenworth, Kansas

OSC File Number DI-24-000869 Parts I and II

November 2024

Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received correspondence from the United States Office of Special Counsel (OSC) in two separate letters (OSC-DI-24-000869, Part I and Part II) referring whistleblower allegations of wrongdoing by employees of the VA Eastern Kansas Health Care System (EKHCS), Dwight D. Eisenhower VA Medical Center (VAMC) in Leavenworth, Kansas.

[redacted], a police officer at Eisenhower VAMC consented to the release of his name and in Part I alleges agency officials violated VA Handbook 0720, Program to Arm Department of Veterans Affairs Police, section 3, part (e), by failing to restrict the access of Officer [redacted] to the facility arms room after he was served with a protective order. Mr. Veith also alleged in Part II that the Eisenhower VAMC police radio system includes dead zones where police radios do not function, and, thus, are not compliant with VA Handbook 0730, Security and Law Enforcement, section 5, Police and Security Operations, part (j). Under the authority of 5 U.S.C. § 1213, OSC concluded that there is substantial likelihood that the information provided to OSC disclosed violations of law, rule, or regulation.

Whistleblower Allegations

1. In OSC-DI-24-000869, Part I, [redacted] alleges that agency officials violated policy by failing to properly restrict VA Police Officer [redacted] s access to the facility arms room after [redacted] was served with a protective order issued by Platte County, Missouri.

2. In OSC-DI-24-000869, Part II, [redacted] alleges that the Eisenhower VAMC police radio system violates policy because there are dead zones where the radios carried by the officers do not function.

Process of the Review

The review of OSC DI-24-000869 Part I was assigned to special agents from the Veterans Health Administration (VHA) Office of the Senior Security Officer (OSSO) and the VA Office of Security and Law Enforcement. Agents conducted an onsite investigation prior to the receipt of the OSC disclosure. The investigation occurred from April 3, 2024, to May 13, 2024. [redacted] was interviewed by agents on April 30, 2024, regarding OSC DI-24-000869 Part I. The review of OSC DI-24-000869 Part II was assigned to agents from VHA OSSO. The investigation occurred from June 26, 2024, to August 10, 2024. [redacted] was interviewed on June 26, 2024, regarding OSC DI-24-000869 Part II.

Part 1 – Allegation, Findings, Conclusions, Recommendations, Actions and Resolutions, Part I

Allegation

1. [redacted] stated that Agency Officials failed to restrict VA Police Officer [redacted]'s access to the facility arms room after [redacted] was served with a protection order issued by Platte County, Missouri prohibiting him from accessing firearms.

Findings.

Investigators found that on March 29, 2024, a VA police lieutenant failed to follow procedures contained in VA Handbook 0720, Program to Arm Department of Veterans Affairs Police; the VA Police Model standard operating procedure (SOP), Chapter IV, section F, Firearms Policy; and the EKHCS Police SOP Chapter VI, section E, Firearms Policy. A protective order issued by Platte County, Missouri prohibited [redacted] from possessing or accessing firearms. The lieutenant failed to act as the on-duty supervisor to revoke [redacted]'s access to the arms room and take his gun box key from him after learning of the protective order. As result, on April 1, 2024, [redacted] retrieved his VA agency issued duty firearm, left VA property, and killed his spouse and child before dying by suicide with the agency weapon. The VA police lieutenant is currently detailed to a non-law enforcement job as the agency evaluates disciplinary action.

Conclusions

Allegation 1 is substantiated. Investigators concluded that the Eisenhower VAMC Chief and Deputy Chief of Police failed to ensure that the VA police lieutenant followed through with the procedures in VA Handbook 0720, Program to Arm Department of Veterans Affairs Police; the VA police model SOP, Chapter IV, section F, Firearms Policy; and the EKHCS police SOP Chapter VI, section E, Firearms Policy, when the VA police lieutenant learned of the existence of the protection order and both were notified. Investigators concluded that both the Eisenhower VAMC Chief and Deputy Chief of Police had concerns regarding the competency and performance of the lieutenant but

did not ensure that [redacted]'s access to the arms room was revoked; therefore, not fulfilling their supervisory and organizational responsibilities.

Investigators also concluded that the Eisenhower VAMC Chief of Police failed to ensure the arms room met the physical security requirements promulgated in VA Handbook 0730, Security and Law Enforcement, Appendix B, Physical Security Requirements and Options. The specific deficiencies found by investigators included the lock to the arms room was not special-keyed[1]; was the same key used for opening the office area where the arms room is located; the audible forced entry alarm was not functioning; and the access card system master control was not password protected.

It was also determined that the Eisenhower VAMC Chief of Police did not consistently follow procedures for revoking arms room access when a VA police officer's arrest and weapons authority was suspended which is a violation of VA Handbook 0720, Program to Arm Department of Veterans Affairs Police; the VA police model SOP, Chapter IV, section F, Firearms Policy; and the EKHCS Police SOP Chapter VI, section E, Firearms Policy.

Recommendations

It was recommended to the Eisenhower VAMC Assistant Director that the physical security deficiencies be corrected immediately. Key access was changed during the investigation to comply with VA Handbook 0730, Security and Law Enforcement, Appendix B, Physical Security Requirements and Options. The alarm broadcasting failure was corrected by a contractor, and the computer controlling access to the armory was protected with a password.

Actions and Resolutions

The Eisenhower VAMC Chief of Police, Deputy Chief of Police, and lieutenant involved in the failure to secure agency firearms after [redacted] was prohibited from firearms access by court order are detailed to non-law enforcement positions as evaluations of disciplinary action occur. The physical security deficiencies have been corrected regarding the Eisenhower VAMC arms room.

VA held an organization-wide safety standdown June 10-14, 2024, at all levels of the organization. VHA, Veterans Integrated Service Networks (VISN), VAMCs leadership, and police officers participated in this event. The focus of the week-long stand down was an examination of all aspects of VA-owned firearm security, processes for suspending or revoking an officer's access, and the tools to strengthen adherence to policy. A statutory arrest suspension checklist was implemented requiring the Chiefs of

[1] Special Key: A key which can only open a lock in a high risk or sensitive area (locally determined), and which cannot be opened by a great grand master, grand master, master or any other individual key. Special keys may also include those that can only open certain doors for cleaning, maintenance, construction, mental health units, and so on.

Police, VAMC Directors, and VISN Security Officers (VSO) to verify that all steps to secure firearms are completed after the suspension of an officer's authority.

Additional safety measures were instituted concerning the actions to take when a VA police officer's arrest and weapons authority is suspended, with additional layers of oversight. VSO conducted physical verification checks of each facility arms room in June 2024 throughout VHA to identify any additional vulnerabilities and take corrective action.

Part II – Allegation, Findings, Conclusions, Recommendations, Actions and Resolutions

Allegation:

2. [redacted] reported that the police radio system includes dead zones, in which police radios do not function, and thus does not comply with VA Handbook 0730, Security and Law Enforcement, section 5, Police and Security Operations, part (j). He reported the problem dated back to at least to the beginning of his employment in 2021.

Findings:

Investigators learned that in 2020, a former Deputy Police Chief (who is no longer employed at VA) approved the purchase of very high frequency portable radios, despite being advised by the company that additional infrastructure of bi-directional amplifiers would be needed to comply with the requirements in VA Handbook 0730, Security and Law Enforcement, section 5, Police and Security Operations, part (j), which states: "Radios, (2) The radio system is designed to prevent dead spots from interrupting communications and will ensure that voice transmissions are easily heard." When a new Chief of Police arrived at the Eisenhower VAMC in late 2020, he noted the deficiencies with the radio system and received quotes for improvements, totaling nearly $2 million to correct the issues. According to the now former Chief of Police's testimony, he was not approved for funding for these specific improvements in fiscal years 2021, 2022, or 2023. However, he did secure funding for a firmware upgrade, and a desktop control station which improved the performance of the system. This Chief of Police transferred to another VA location in August 2023.

The current VA Eisenhower VAMC Chief of Police was the Deputy Chief of Police and became the permanent Chief of Police in January 2024. He was the Acting Chief of Police from August 2023, until being selected in January 2024. In February 2024, the Eisenhower VAMC Police Service submitted a contracting package for the needed improvements. The facility approved the funding; and as of the investigation, the matter is in a contracting status and near awarding for work to begin.

Investigators conducted a review of radio performance and inspected the equipment during the investigation at Eisenhower VAMC on June 26, 2024. The acting Assistant

Chief of Police and investigators inspected the portable radios being used by the officers. A check of the rechargeable batteries being used for the radios was done. Radio batteries from this manufacturer have a date stamp, indicating the year and week of production. The recommendation is to replace batteries every 18-24 months and have a warranty against defects until the 24th month after production.

Investigators found batteries in use that were produced in 2019 and 2021 and past the recommended replacement date. The battery life and capacity affect the range and operation of portable radios, which, more than likely, contributed to the complaints of radio performance. Investigators using a freshly charged battery successfully transmitted and received radio communications in the areas [redacted] and others identified as "dead spots", including police operations, the domiciliary, and the National Cemetery.

Conclusions:

Allegation 2 is substantiated. The lack of oversight by the Eisenhower VAMC Chief of Police in maintaining portable radio batteries within the recommended use of life is concluded to be a contributing factor to radio performance, a violation of VA Handbook 0730, Security and Law Enforcement, section 5, Police and Security Operations, part h, which states: "Emergency Communications and Response Capability, (1) The means for rapidly contacting center police from all areas of the facility during emergencies by telephone, radio, or duress alarms are ensured."

Recommendations:

No recommendations were made.

Actions and Resolutions:

The Eisenhower VAMC Chief of Police is currently conducting non-law enforcement duties as potential disciplinary action is considered for the findings concerning the condition of the radio batteries as found by investigators. The investigators confirmed with VA contracting and the Eisenhower VAMC Assistant Chief Financial Officer that the radio improvement contract is funded, and close to award in compliance with Fair Acquisition Regulations and other applicable contract award laws and policies.

Department of Veterans Affairs
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