DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

JUL 9 2012

In Reply Refer To:

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M. Street, N.W. Suite 300
Washington, DC 20036-4505
Attn: Catherine A. McMullen, Chief, Disclosure Unit

Re: OSC File No. DI-12-0886

Dear Ms. Lerner:

We hereby request that your office publish the enclosed redacted version of the Department's response to allegations reported by a VA Police Officer at the Canandaigua VA Medical Center (VAMC) regarding the PIV card issuance process at the Bath VAMC (OSC DI-12-0886). During the time frame of the allegations, the Whistleblower was employed as a Police Officer at the Bath VAMC. VA's response identifies the individuals who were interviewed during the investigation, or who conducted the investigation, by names and/or job titles.

Under the FOIA, we assert that a report of this nature should be partially redacted pursuant to exemptions (b)(6) and (b)(7)(C). Exemption (b)(6) requires that an agency determine whether disclosure "would constitute a clearly unwarranted invasion of personal privacy" by balancing the privacy interest that would be compromised by disclosure against the public interest in the requested information. Exemption (b)(7)(C) protects law enforcement information the disclosure of which "could reasonably be expected to constitute an unwarranted invasion of personal property."

Clearly the public has an interest in knowing how its government operates and that wrongdoing is addressed adequately. However, it has been held that career public servants retain personal privacy interests in the discharge of their public duties. New England Apple Council, Inc. v. Donovan, 725 F.2d 139 (1st Cir. 1984). This is particularly true in cases involving the investigation of alleged wrongdoing, as in this case. Federal employees also have personal privacy interests when disclosure of their identities could lead to harassment. In the case at hand, the investigation did not substantiate the Whistleblower's allegations that the named employee directed the improper issuance of Personal Identity Verification (PIV) cards. The employees who were interviewed or conducted the investigation are career public servants and mid to low-level employees. The cooperation of rank and file employees is needed in any

investigation to get a full and complete picture of what actually took place. The employees have a strong privacy interest in their identities, which are inextricably tied to their professional and personal reputations and their roles as employees. Their privacy interest outweighs the public's interest in knowing all of the details of the investigation. Further, their involvement in an investigation that involves a potentially contentious situation may result in embarrassment or harassment. Accordingly, the individuals who were interviewed or conducted the investigation have substantial privacy interests in their identities.

Protecting the identities of the employees may be accomplished by redacting their names and identifying details and providing the public a redacted copy of the material. By providing a redacted copy of the information to the public, OSC would reveal general information about the investigation, thus satisfying the public interest, while protecting the employees' privacy.

This result is consistent with case law, as courts have held that serious and less serious misconduct by low-level agency employees does not raise sufficient public interest to outweigh the privacy interest of the employee. *Forest Serv. Employees for Envtl. Ethics v. U.S. Forest Service*, 524 F. 3d 1021, 1025 (9th Cir. 2008). Courts have typically extended protection to the identities of mid-and low-level federal employees accused of misconduct, as well as to the details and results of any internal investigations into such allegations of impropriety. *Stern v. F.B.I.*, 737 F.2d 84, 94 (D.C. Cir. 1984).

If you have any questions about this request, please contact Sharon M. Johnston in the Office of General Counsel at 202-461-7658.

Sincerely yours,

Walter A. Hall
Assistant General Counsel

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
July 5, 2012

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: OSC File No. DI-12-0886

Dear Ms. Lerner:

This is in response to your letter regarding allegations reported by [redacted], a Department of Veterans Affairs Medical Center (VAMC) [redacted] at the Canandaigua VAMC in Canandaigua, New York. During the timeframe of the allegations, [redacted] was a [redacted] at the Bath VAMC in Bath, New York. [redacted] alleged that [redacted] VAMCs, directed the improper issuance of Personal Identity Verification (PIV) cards by ordering [redacted] to enter PIV-required employee information into the PIV system and issue PIV cards prior to completion of [redacted] background check and without proper training. [redacted] also alleged that the [redacted] directed the [redacted] to enter [redacted] employee and personal information into the VA and Department of Justice computer systems under a false badge number to enable [redacted] to issue PIV cards. You asked me to determine whether the information in [redacted] allegations disclosed a violation of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public safety.

I asked the Under Secretary for Health to review this matter and conduct an investigation for purposes of providing your office with a report as required under 5 U.S.C. § 1213(c) and (d). He, in turn, referred the matter to the Veterans Integrated Service Network 2 and the Bath VAMC for investigation. An Administrative Investigation Board (AIB) conducted a fact-finding investigation, interviews and documentation reviews from April 2-25, 2012, and produced the enclosed report. The AIB determined that the evidence does not substantiate the allegations that the [redacted] directed the improper issuance of PIV cards. However, the AIB did find that the Bath VAMC did not have a policy in place for retention of PIV training records, and routinely destroys them when an employee leaves VA employment. The AIB also found that [redacted] PIV training records had been destroyed shortly after [redacted] The AIB recommended that the Bath VAMC develop a standard policy, consistent with the regulatory record control schedules, for retention of PIV training records for current and former employees.

The Honorable Carolyn N. Lerner

I have reviewed the report and concur with the findings, conclusions and referral for corrective action. VHA will monitor the implementation of corrective action to ensure it is taken. Thank you for the opportunity to respond to this issue.

Sincerely,

Eric K. Shinseki

Enclosure

Report to the
Office of Special Counsel
OSC File Number DI-12-0886

Department of Veterans Affairs
Bath Medical Center
Bath, NY

Veterans Health Administration
Washington, DC

Report Date: May 23, 2012

Updated (June 14, 2012)

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

The Under Secretary for Health requested that the Veterans Integrated Service Network (VISN) 2 and the Bath VA Medical Center (VAMC) investigate a complaint lodged with the Office of Special Counsel by Department of Veterans Affairs (VA) employee, [redacted] through whistleblower disclosure, at the Department of Veterans Affairs Canandaigua VAMC. [redacted] alleged that the [redacted] directed the improper issuance of Personal Identity Verification (PIV) cards by (1) ordering [redacted] to enter PIV required employee information into the VA PIV system and issue PIV cards prior to completion of [redacted] background check, (2) perform PIV roles (that of Registrar and Issuer) without proper training, and (3) the [redacted] directed the [redacted] to enter [redacted] employee and personal information into the VA and Department of Justice computer systems under a false badge number to enable [redacted] to issue PIV cards.

An Administrative Investigation Board (AIB) was chartered (March 26, 2012) and directed to conduct a thorough fact-finding investigation into these allegations. There was an initial delay in interviewing witnesses as [redacted]

Summary of Conclusions

AIB completed their investigation of each allegation and concluded that each allegation regarding the fraudulent issuance of PIV cards to be unsustained. No testimony, direct or indirect, or documents reviewed indicates that there was a single card obtained in a fraudulent or inappropriate manner.

The AIB made an additional finding that the PIV training records for [redacted] had been destroyed shortly after [redacted] This appears to be consistent practice at the Bath VAMC, as the AIB attempted to review PIV training records of retired employees who previously held a role in the PIV process, but their records were also destroyed. The AIB determined that the Bath VAMC did not have a standard policy governing retention of PIV training records. The Bath VAMC did not fully comply with the regulatory requirements in Records Control Schedule (RCS) 10-1 Item 25 and General Records Schedule 1 Item 29a(1), which require that training records in an employee's training and education file be retained for 5 years, irrespective of whether the employee leaves employment.

Summary of Recommendations

AIB recommends that the medical center develop a standard policy governing retention of PIV training records that is consistent with the regulatory requirements in RCS 10-1 Item 25 and General Records Schedule 1 Item 29a(1).

Report to the Office of Special Counsel

I. SUMMARY OF INFORMATION

An investigation was conducted in response to Office of Special Counsel (OSC) File No. DI-12-0886 regarding allegations made by VA employee, [redacted] alleged that [redacted] VAMCs, directed the improper issuance of PIV cards by ordering the employee to enter PIV required employee information into the VA PIV system and issue PIV cards prior to completion of the employee's background check and without proper training. [redacted] also alleged that the [redacted] directed the [redacted] to enter [redacted] employee and personal information into VA and Department of Justice computer systems under a false badge number to enable [redacted] to issue PIV cards. A subsequent investigation did not uncover any violation of statutory laws governing the PIV Program. However, the investigation did find that the Bath VAMC did not fully comply with regulatory RCS 10-1 Item 25 and General Records Schedule 1 Item 29a(i) for retention of training records.

II. FACILITY PROFILE

The Bath VAMC is a Joint Commission accredited, complexity level 3 facility serving Veterans in two states. The VAMC is located in Bath, New York, and the community-based outpatient clinics (CBOC) are located in Elmira and Wellsville, New York. In addition, CBOC satellite clinics are now located in Mansfield and Coudersport, Pennsylvania. Bath VAMC is a part of VISN 2, which includes facilities in Albany, Buffalo, Syracuse and Canandaigua, New York.

Bath VAMC serves Veterans throughout the Southern Tier of New York (Allegany, Chemung, Schuyler, Steuben and Yates counties) and Northern Pennsylvania (Tioga and Potter counties). The facility provides primary medical care, emergency room services, acute care, nursing home care (Community Living Center), behavioral health outpatient services, and maintains a Domiciliary Residential Rehabilitation Treatment Program.

III. CONDUCT OF THE INVESTIGATION

The AIB team was comprised of three VA employees from the VA Western New York Healthcare System, chaired by Mr. Royce Calhoun, Assistant Director who conducted their investigation in accordance with VA Directive 0700 and VA Handbook 0700 Administrative Investigations (AI), and the Network AI Policy. Other board members were [redacted] and a human resource assistant.

Investigation, interviews and documentation reviews were conducted from April 2-25, 2012. Seven witnesses were interviewed during this time. The Bath VAMC [redacted], who [redacted] was contacted but chose not to be interviewed for this investigation.

The following employees were interviewed during this investigation:

[redacted]

David Krueger, Associate Medical Center Director, Bath VAMC, PCI Manager

[redacted] Bath VAMC

The Whistleblower, [redacted], Canandaigua VAMC

[redacted] Bath VAMC

[redacted], Bath VAMC

[redacted], Bath VAMC

The AIB investigated whether the [redacted] VAMCs directed the improper issuance of PIV cards by (1) ordering [redacted] to enter PIV required employee information into the VA PIV system and issue PIV cards prior to completion of [redacted] background check, and (2) perform two PIV roles (that of Registrar and Issuer) without proper training. The AIB also investigated whether the [redacted] directed the [redacted] o enter [redacted] employee and personal information into the VA and Department of Justice computer systems under a false badge number to enable [redacted] to issue PIV cards.

IV. SUMMARY OF EVIDENCE OBTAINED FROM THE INVESTIGATION

The following is a summary of AIB's findings based on the information obtained through the investigation process, including interviews, review of documents obtained and examination of the physical layout of the PIV Office.

1. Did the [redacted] order [redacted] to perform PIV roles before [redacted] own background investigation was completed?

Findings:

1. At the time of the allegations, there were no clear and consistent PIV instructions or directions concerning whether an individual holding a PIV role must have a completed and favorably adjudicated background investigation (at a National Agency Check with Written Inquiries (NACI) or higher level investigation) prior to assuming PIV role responsibilities.

    a. Federal Information Processing Standards (FIPS) 201-1 (March 2006), sections 2.2, 2.3 and 5.3.1, provide that a PIV card may be issued to an employee or contractor where a NACI or higher level background investigation is pending, provided a fingerprint check has been completed. In such cases, the PIV issuance process must

verify successful completion and adjudication of the background investigation. Where the results of the background investigation so justify, a PIV card may be revoked.

b. VA Directive 0735, Homeland Security Presidential Directive 12 (HSPD-12) Program, issued February 17, 2011, assigns responsibility for management of the PIV operations and credential life cycle at a facility to the PIV role of PCI Manager, including, in part, the responsibility for "ensuring initiation and completion of appropriate employee, contractor, and affiliate background checks prior to issuing a badge." The Directive does not state that a NACI or higher level background investigation must be completed and favorably adjudicated prior to the issuance of a PIV card or an individual's assumption of PIV roles.

c. VA's current PIV training Web site requires prior completion and favorable adjudication of a NACI or higher level investigation for Registrars and Issuers.

   i. All Registrars must have a completed favorable background investigation (at the NACI level or higher), complete the HSPD-12 Registrar training, be appointed and certified by a PCI Manager, and be issued a PIV card before beginning HSPD-12 Registrar responsibilities.

   ii. All Issuers must have a completed favorable background investigation (at the NACI level or higher), complete the HSPD-12 Issuer training, be appointed and certified by a PCI Manager, and be issued a PIV Card before beginning HSPD-12 Issuer responsibilities.

2. During our investigative interview, the Bath PCI Facility was unaware that individuals in PIV roles must have a completed and favorably adjudicated background investigation (NACI or higher level) prior to performing PIV role responsibilities. The Bath PCI Facility is now fully aware of the requirement and has verified all active role members have had the appropriate background investigation completed prior to PIV role assignment.

3. [redacted] was issued a PIV card on [redacted]

4. VA police officers are required to undergo a Minimum Background Investigation (MBI). An MBI includes all the components of a NACI, plus additional components such as a subject interview and a credit history for 7 years. A VA police officer is issued a police badge and police identification card (which provides authority to carry the Department firearm) only after successful adjudication of the MBI.

5. [redacted] NACI was closed on [redacted] and favorably adjudicated on [redacted] MBI was closed on [redacted], and favorably adjudicated on [redacted]

6. [redacted] testified tha[redacted] was assigned to work in the Bath PIV Office in mid-to-late [redacted], following [redacted] return from [redacted] (page 14 of [redacted] transcript).

7. At the time of the AIB investigation, the PIV enrollment portal report, under PIV user option, indicates that [redacted] had been involved in the PIV badge process as either a Registrar or an Issuer on 9 specific occasions: [redacted] (1 time); [redacted] (4 times), [redacted] (3 times) and [redacted] (1 time).

8. [redacted] performed a PIV role in [redacted] before [redacted] MBI was favorably adjudicated on [redacted]. However, the favorable adjudication of [redacted] NACI on [redacted], predates [redacted] assignment to the [redacted] and satisfies the requirement that a NACI or higher level investigation be completed and favorably adjudicated prior to assuming PIV role responsibilities.

Conclusion:

The AIB does not substantiate the allegation that [redacted] performed PIV duties prior to having [redacted] background investigation closed and adjudicated.

Recommendation:

The AIB makes no recommendation regarding this allegation.

2. Did the [redacted] require [redacted] to perform two PIV roles (that of Registrar and Issuer)?

Findings: FIPS 201-1, section 2.2, provides that "[t]he PIV identity proofing, registration and issuance process shall adhere to the principle of separation of duties to ensure that no single individual has the capability to issue a PIV credential without the cooperation of another authorized person." FIPS 201-1, Appendix A, section A.2.2, provides that ("[r]oles are not defined to mandate that a single individual within an organization must fulfill any given role." Accordingly, a PIV role official may not perform more than one role in the PIV process for a single card applicant. However, FIPS 201-1 does not preclude an individual from serving in two different PIV roles, provided the roles are performed at different times and not for the same card applicant. The PIV enrollment portal report shows that [redacted] did not serve as both Registrar and Issuer for any single card applicant.

The Assistant Secretary for Operations, Security, and Preparedness issued HSPD-12 Policy Memorandum 11-003 (October 17, 2011) to reiterate policy prohibiting PIV enrollment station staff from performing more than one role for an individual applicant.

The interviews conducted and documents reviewed all demonstrated that all staff involved in the PIV process is well versed in the requirements of the PIV program and the principle of

separation of duties. The AIB also examined the physical layout of the PIV office. The AIB found no evidence where the separations of duties were compromised.

Conclusion:

The AIB does not substantiate the allegation that the required PIV separations of duties were compromised.

Recommendation:

The AIB makes no recommendation regarding this allegation.

3. Did the [redacted] order [redacted] to assume the PIV roles before [redacted] completed proper training?

Findings: VA Directive 0735 requires training for individuals to fulfill PIV roles (PCI Manager, Sponsor, Registrar, Issuer and PIV Card Applicant Representatives). Training cannot be confirmed by examination of [redacted] PIV training records, since the records were shredded when [redacted] to the Canandaigua facility. This appears to be consistent practice at the Bath VAMC, as the AIB attempted to review training records for retired employees who previously held a role in the PIV process, but their records were also destroyed.
There is inconsistent testimony regarding whether [redacted] received the proper training prior to assuming a PIV role. [redacted] testified that [redacted] remembers printing out and giving training paperwork (articles and test) to [redacted] (pages 2-3 of [redacted] transcript), that [redacted] worked on the test in the police operations office across the hall in the presence of another police officer (who is no longer with the Bath VAMC) (page 4 of [redacted] transcript), and that [redacted] gave [redacted] in-person training at the Issuer station on each step of the PIV Issuer role (page 3 of [redacted] transcript). [redacted] also testified that [redacted] never complained that [redacted] did not receive adequate training (page 4 of [redacted] transcript). [redacted] stated that [redacted] would not have received privileges unless [redacted] handed in the test and it was graded by the Chief (page 3 of [redacted] transcript). [redacted] testified that [redacted] never received any official training (page 4 of [redacted] transcript), was only shown how to fill in the blanks in the computer (pages 4, 14 of [redacted] transcript), and never read any materials or took the test (pages 14-15 of [redacted] testimony).

VA Handbook 0700, Administrative Investigations, Chapter 1, Section C, paragraph 8, requires an AIB to analyze evidence to determine the facts that are not subject to reasonable dispute, and draw conclusions regarding other issues to the extent justified by the available evidence. The interviews of all witnesses and the training records that the AIB reviewed all demonstrated a consistent pattern of training received with in-person assistance for users in the PIV office, when needed on each step of the PIV process. The training records reviewed were all kept and maintained in a secure area within the PIV office. We acknowledge the inconsistent testimony from [redacted] and [redacted] but found the testimony of the [redacted] to be most credible.

Conclusion:

The AIB does not substantiate that [redacted] did not receive adequate PIV training before being assigned PIV roles.

Recommendation:

The AIB recommends that the facility develop a standard policy, consistent with the regulatory requirements of RCS 10-1 Item 25 and GRS 1 Item 29a(1), for maintenance and retention of PIV training records.

4. Did the [redacted] order the [redacted] to enter [redacted] employee and personal information into the VA and Department of Justice computer systems under a false badge number to enable [redacted] to issue PIV cards?

Findings: The interviews of all witnesses failed to identify anyone who witnessed the sharing of cards and any wrong doing while performing the roles in the PIV process. The physical layout of the PIV office supports the fact that others are in close proximity where such wrong doings could be easily witnessed. [redacted] was specifically asked questions related to the sharing of badges and access code in [redacted] interview dated April 19, 2012. Page 10 of [redacted] testimony revealed the following question and response from [redacted]: when asked if [redacted] used the [redacted] badge to enter data, [redacted] responded, "Just a few times. Two, three, four, five and then I started using my (PIV) badge…." During questioning, [redacted] stated that the [redacted] never provided [redacted] with [redacted] access code, but would sign in, instruct [redacted] on what steps were needed and then would review and release the work by typing in [redacted] own access code to digitally sign and release the action. (pages 10, 13, 16 of [redacted] transcript). Once competency was reached, [redacted] was able to perform the task without the aid of the [redacted] using [redacted] own PIV Badge.

Conclusion:

The AIB does not substantiate that the [redacted] directed the [redacted] o enter [redacted] employee and personal information into the VA and Department of Justice computer systems under a false badge number to enable [redacted] to issue PIV cards

Recommendation:

The AIB makes no recommendation regarding this allegation.

V. VIOLATIONS/APPARENT VIOLATIONS OF LAW, RULE OR REGULATION

The investigation did not uncover any violation of statutory laws governing the PIV Program. The AIB completed their investigation of each allegation and concluded that each allegation regarding the fraudulent issuance of PIV cards to be unsustained. The testimony, direct or indirect, and documents reviewed, as well as the physical layout of the PIV office, do not indicate that there was a single card obtained in a fraudulent or inappropriate manner. However, the investigation did find that the PIV training records for [redacted] had been destroyed shortly after [redacted]. The AIB also found that the Bath VAMC did not have a standard policy governing retention of PIV training records, and its consistent practice was to destroy such records when an employee left employment. The Bath VAMC did not fully comply with the regulatory requirements in RCS 10-1 Item 25 and General Records Schedule 1 Item 29a(i), which require that training records in an employee's training and education file be retained for 5 years, irrespective of whether the employee leaves employment.

VI. ACTIONS TAKEN OR PLANNED

During our investigative interview, the Bath PCI Facility was unaware that individuals in PIV roles must have a completed and favorably adjudicated background investigation (NACI or higher level) prior to performing PIV role responsibilities. The Bath PCI Facility is now fully aware of the requirement and has verified all active role members have had the appropriate background investigation completed prior to PIV role assignment.

VHA concurs with the additional findings and will follow-up with the Bath VAMC to ensure that corrective action is taken.

Documents Reviewed:

June 2011 PIV Card Operations Plan – Bath

June 2011 PIV Card Operations Plan – Canandaigua

Director, HSPD-12 Program (07C1) PIV Issuance Accreditation Review – Bath, January 19, 2012

Director, Office of Personnel Security and Identity Management (07C) Review – Bath, January 19, 2012

Training Records of all employees interviewed

AIB Transcripts of all employees interviewed

PIV Training Web site – FIPS Publication 201-1