THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 11, 2011

Mr. William E. Reukauf
Associate Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036

Re: OSC File No. DI-10-0157

Dear Mr. Reukauf:

I am responding to your letter regarding allegations reported by Mr. Donald Woodworth, a Department of Veterans Affairs medical center (VAMC) Police Officer at the Canandaigua, New York, VAMC. Mr. Woodworth alleged that employees at the VAMC improperly issued Government-mandated Personal Identity Verification (PIV) credentials by sharing credentials to allow a single person to issue PIV badges instead of maintaining proper separation of duties as required by Federal standards.

VA has thoroughly investigated Mr. Woodworth's allegations. A fact-finding inspection and follow-up interviews were conducted to investigate this allegation and produced the enclosed report. The evidence substantiates the allegation that employees violated Federal standards and VA policy concerning the PIV credential issuance, and that several individuals were apprised of the allegations prior to the fact-finding inspection, but failed to take immediate action to investigate the matter.

VA has taken several steps to address this issue to ensure the integrity of the PIV badge issuance process. System integrity remains a paramount element of VA's PIV enrollment program. VA staff has terminated PIV badge creation authority for the parties involved, counseled the other Canandaigua VAMC PIV Enrollment Team members, and issued policy communications nationwide to ensure PIV issuance roles and responsibilities are clearly communicated to all VA PIV enrollment offices. Veterans Health Administration leadership is currently taking corrective action based on the findings, including appropriate administration action as deemed appropriate for the individuals who acknowledged violating the PIV policy and procedures, and for those who failed to timely investigate the matter once they were apprised of the allegations.

I have reviewed the report and concur with the findings, conclusions and corrective actions. Thank you for the opportunity to respond to these issues.

Sincerely,

Eric K. Shinseki

Enclosure

REPORT SUMMARY: OSC File No. DI-10-0157

I. SUMMARY OF INFORMATION

An investigation was conducted in response to Office of Special Counsel (OSC) File No. DI-10-0157 regarding allegations made by a Department of Veterans Affairs (VA) employee, Mr. Jerry Woodworth. He disclosed that VA employees improperly issued identification cards to employees and possibly contractors and visitors at the Canandaigua VA Medical Center (VAMC). A subsequent investigation revealed that the VAMC Director and Associate Director had prior knowledge of the violations.

II. CONDUCT OF THE INVESTIGATION

Special Agent Jerry Brown was assigned to conduct a field investigation regarding the whistleblower disclosure. The investigation began on Tuesday, May 11, 2010, with interviews of all individuals involved and reviews of available evidentiary documentation.

Investigation, interviews and documentation reviews were conducted from May 11 - May 13, 2010. Nine witnesses were interviewed during this time. A follow-up investigation to assess whether the Director and Associate Director were apprised of the allegations prior to the fact-finding inspection of May 2010 was conducted on January 20, 2011.

The following is a summary of the findings from these interviews and review of the Personal Identity Verification (PIV) Office procedures it was determined that:

1. Several Police Service employees at the Canandaigua VAMC had participated in activities that were in violation of the Federal Information Processing Standards (FIPS-201) 1.3.

2. During the interview process with Special Agent Brown, the Assistant Chief of Police and a Police Officer both admitted to violating the PIV policy and procedures.

3. The Associate Director and the Chief of Police denied any knowledge of PIV program violations prior to the May 2010 investigation.

4. Interviews with other Police Service staff confirmed that the Chief of Police had knowledge of the PIV program violations and did indirectly instruct officers to do whatever was required to process and issue PIV cards.

5. The Assistant Chief of Police provided his badge and Personal Identification Number (PIN) to a Police Officer to use while the Assistant Chief was on annual leave.

6. The follow up investigation revealed that the Director and Associate Director, in fact, were apprised of the allegations regarding the Police Service PIV card issuance violations prior to the fact-finding inspection of May 2010, but no investigation into the matter was conducted.

III. SUMMARY OF EVIDENCE

1. Based on the information obtained through the interview process of this investigation and documentary evidence provided by a witness, there has been a clear violation in the separation of duties related to PIV Enrollment Operations at the facility. Information provided during interviews indicates that the Chief of Police not only had prior knowledge of the violation but also participated in the violations. According to the documentary evidence provided, the Director, Associate Director and the Chief of Police had knowledge of the allegations as early as September 21, 2009, but no investigation was conducted into the allegations. Since the PIV card and PIN provide a digital signature, there are several violations associated with falsification of Government documents under 18 U.S.C. §1001 and 18 U.S.C. §1028.

2. Based on the investigation findings, Mr. Brown referred the case to the Assistant United States Attorney for the Western District of New York for guidance on whether the case merited criminal charges involving the falsification of government documents. On August 11, 2010, the Assistant United States Attorney notified Investigator Brown that the U.S. Attorney declined to pursue criminal charges. Their decision was based upon the lack of criminal intent and the lack of benefit derived in the unauthorized manufacture of the PIV cards other than being contrary to procedure. The Assistant United States Attorney concluded that the case did not appear to warrant criminal prosecution and any action taken against the individuals involved should be made by the agency itself.

IV. SUSTAINED OR UNSUSTAINED VIOLATIONS

1. Results of this investigation have confirmed violations of the Federal Information Processing Standards (FIPS-201) 1.3 PIV Roles as indicated in Presidential Directive (HSPD-12) dated August 27, 2004. FIPS 201-1 requires a separation of PIV Official roles during the PIV card issuance process. A PIV Official cannot perform more than one role in the PIV issuance process for a single card applicant (for example, a PIV Sponsor cannot serve as a PIV Registrar or Issuer for an applicant that he or she sponsored).

2. Based on the evidence and testimonies provided by witnesses during this investigation, it is apparent the Assistant Chief of Police provided his PIV card

and PIN to another Police Officer to allow processing of PIV cards while the Assistant Chief was on Annual Leave. Both the Assistant Chief of Police and the Police Officer involved admitted during their interviews that they had violated PIV policy and procedures.

3. The Associate Director and the Chief of Police both stated during their interviews of having no knowledge of any PIV program violations prior to the investigator's notification on May 10, 2010. The Vice President of Service Employees International Union Local 200U stated during her interview that she was made aware of the PIV violations by one of her union constituents. The investigator was provided with documentary evidence in the form of an e-mail message sent to the Medical Center Director, Associate Director, and the Chief of Police on September 21 and September 28, 2009, describing the PIV violations being performed by police staff and requesting the process of police staff using each other's PIV cards to cease. The Medical Center Director directed the Associate Director to investigate the matter and take appropriate action, but no investigation was conducted prior to the initial investigation conducted in May 2010. Accordingly, the Director, Associate Director, and the Chief of Police did have knowledge of the allegations, but the Associate Director and Chief of Police failed to take appropriate action and the Director failed to follow up to ensure the matter was investigated.

V. ACTIONS TAKEN

1. The Canandaigua VAMC leadership took corrective action based on the findings of the inspector, including issuance of written counseling for the lower-level Police Service employees and reprimands for the Assistant Chief of Police and Chief of Police who acknowledged violating the PIV policy and procedures.

2. Veteran's Health Administration's Veterans Integrated Service Network 2 leadership over Canandaigua VAMC took corrective action based on the findings of the inspector. The VAMC Director was orally counseled for failing to follow-up to ensure the matter had been investigated and a letter of counseling was to the VAMC Assistant Director for failing to timely investigate the matter.

3. The HSPD-12 Program Office has suspended badging privileges of those individuals found to have violated FIPS 201 requirements.

4. The HSPD-12 Program Office has implemented a communications plan in which all VA PIV Office teams were advised of the requirement to maintain a separation of roles for Sponsors, Registrars, and Issuers.