U.S. OFFICE OF SPECIAL COUNSEL
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Washington, D.C. 20036-4505

The Special Counsel

February 28, 2025

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-24-000869

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA) in response to the Special Counsel's referral of disclosures of wrongdoing at the Eastern Kansas Health Care System, Dwight D. Eisenhower Department of Veterans Affairs Medical Center (Eisenhower VAMC), Leavenworth, Kansas. I have reviewed the disclosure, the agency report, and the whistleblower's comments, and in accordance with 5 U.S.C. § 1213(e), I have determined that the report contains the information required by statute, and the findings appear reasonable. The VA's Office of the Senior Security Officer and the VA Office of Security and Law Enforcement conducted the investigation. The allegations were substantiated. The following is a summary of the findings and whistleblower comments.

The Allegations

The whistleblower, Police Officer [redacted] who consented to the release of his name, made two distinct allegations that were referred individually under the same case number referenced above. In Part I of OSC's referral, [redacted] alleged that Eisenhower VA Police Department management did not remove access to agency firearms from officer [redacted] in accordance with VA Handbook 0720, *Procedures to Arm Department of Veterans Affairs Police*, in response to a March 25, 2024 protective order issued by Platte County Circuit Court, Platte County, Missouri. The protective order prohibited, among other things, [redacted] from possessing firearms. Following the receipt of the protective order, officers confiscated Mr. McGeachy's badge and credentials on March 29, 2024, but did not confiscate his keys and PIV card. With the keys and PIV card, [redacted] was able to unlock the Eisenhower VAMC armory door and access the police department's weapons. [redacted] stated that the police department was advised on April 1, 2024, that [redacted] had killed his wife and child, and committed suicide, and that a weapon was missing from the VA armory.

In Part II of OSC's referral, [redacted] alleged that the VA police radio system at Eisenhower VAMC did not fully cover the facility's campus, thus violating VA Handbook 0730,

Security and Law Enforcement.[1] [redacted] explained that on the Eisenhower VAMC campus there were persistent "dead zones" in which police radios could not reach one another. These dead zones included areas in the Police Department, rooms in the medical center, the rehabilitation domiciliary, and portions of the National Cemetery. [redacted] explained that officers in these dead zones are unable to request backup or assistance as necessary. He stated that problems related to the radios dated from at least 2021.

The Agency Report

a. Part I

Following a site visit to the facility, investigators concluded that the Eisenhower VAMC Chief and Deputy Chief of Police failed to follow the procedures in VA Handbook 0720 when they failed to ensure that a VA Police lieutenant prevented [redacted] from accessing the facility armory and that the Chief of Police regularly failed to follow procedures for revoking access to the armory when a VA police officer's arrest and weapons authority was suspended. Security deficiencies were also identified, specifically the lock on the door to the armory was not special-keyed[2] and the same key was used to open the office area where the armory is located, the audible forced entry alarm was not functioning, and the access card system master control was not password protected.

Following the investigation, the physical security deficiencies were corrected immediately. The lock to the armory door was special-keyed, the alarm broadcasting failure was corrected, and the computer controlling access to the armory was protected with a password. The VA also held an organization-wide safety standdown June 10-14, 2024, and outlined additional safety measures for staff to take when a VA police officer's arrest and weapons authority is suspended. In June 2024, Veterans Integrated Services Network Security Officers conducted physical verification checks of all arms rooms throughout the Veterans Health Administration to identify any additional vulnerabilities and take corrective action.

In February 2025, OSC received an update on the status of disciplinary action taken against VA employees. In its response, the VA informed OSC that disciplinary action was taken, or is pending, against the Eisenhower VAMC Chief of Police, Deputy Chief, and a Lieutenant who are no longer in police service.

[1] *See* VA Handbook 0730 § 5(j) ("The radio system is designed to prevent "dead spots" from interrupting communications and will ensure that voice transmissions are easily heard.")
[2] According to the agency report, a Special Key is, "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."

b. Part II

The investigation substantiated [redacted] allegation that the police radio system at Eisenhower VAMC had dead spots and did not fully cover the facility's campus. Investigators inspected the radio units and found batteries powering many of them were past the recommended replacement date. Investigators concluded that these batteries likely affected the range and operation of portable radio and caused the dead zones. Investigators confirmed with VA contracting and the Eisenhower VAMC that there is a contract currently out for bid to improve the radio systems at the facility.

The Whistleblower Comments

[redacted] confirmed that policies have been established to ensure more stringent control over access to firearms. However, he expressed concern about the VA's slow pace to make personnel decisions following the investigation's findings and its effect on the VA Police Department's ability to hire replace staff.[3]

Regarding Part II, [redacted] confirmed that the radio system is gradually being updated to address existing deficiencies.

The Special Counsel's Findings

I thank the whistleblower for bringing the allegations to OSC. As a result of the investigation, the agency identified and corrected serious safety deficiencies that will hopefully prevent future tragedies like the one that prompted this investigation. I join the Kansas City community in mourning the tragic loss of life.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, and whistleblower comments to the Chairs and Ranking Members of the Senate and House Committee on Veterans Affairs. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available online at osc.gov. This matter is now closed.

Respectfully,

Hampton Dellinger

Hampton Dellinger
Special Counsel

Enclosures

[redacted] concerns about the pace of personnel decisions were submitted prior to VA's February 2025 update.