Roselyn Tolliver
[redacted]

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1730 M St., NW Suite 300
Washington, D.C. 20036

RE: OSC File No. DI-15-2365, DI-15-2840, DI-15-3317

Dear Mr. Young:

This letter is in response to the *Follow-up Review on the Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California* by the Office of Special Counsel (OIG), dated January 8, 2016. It appears that OIG did a thorough second investigation and determined that this incident was not handled properly by agency management. However, the first review reads the same as the second: both had the same finding and the same insignificant repercussions for the agency.

Where is the disciplinary action? Why has no one been held accountable for a scandal of this magnitude? How can the only consequence be additional staff training? It is unfathomable to me that anyone could read these reports and not be outraged by the incompetence and lack of concern for veterans and their families. The only way OIG's recommendations are acceptable is if it cannot impose penalties on the agency.

My final comments are based on the first OIG review, dated February 18, 2015. On page 1 it states, "A Veterans Benefits Administration (VBA) management support team, sent to assist with operations of the Oakland Veterans Service Center from October through November 2012, found in a file cabinet approximately 14,000 informal claims dating back to the mid-1990s. VARO staff stated they counted the documents and found 13,184 informal claims, of which 2,155 still required processing action". Below is a quote from this report on page 2, which states OIG's findings:

> We substantiated the allegation that Oakland VARO staff had not processed a significant number of informal requests for benefits dating back many years. However, we could not confirm that VARO staff processed all of the informal claims found in October 2012, nor could we confirm the initial list contained 13,184 informal claims because of management's poor record keeping practices. Further, we substantiated Oakland VARO staff did not properly store 537 informal claims because these claims were not discovered until the office was undergoing a construction project. Some of these informal claims dated back to July 2002. The 537 informal claims, documented by VARO management in June 2014, appear to be part of the original list found by VBA's special review team in October 2012; however, poor record keeping practices limit our ability to confirm this fact.

I have several problems with this review:

1. The statement, "...nor could we confirm the initial list contained 13,184 informal claims because of management's poor record keeping practices": Even if the initial number was off, the amount of paperwork that the VBA support team found had to be massive if was estimated to be 14,000. The fact that thousands of claims went missing needed more extensive inquiry.
2. The number of informal claims that got reduced from 13,184 to 2,155 when "VARO staff", who aren't named, claimed that this was the number that needed processing. It's hard to believe that over 80% of the documents found didn't contain vital information or need to get filed down in the vet's folder, because some of them had to have had C-files. In addition, was documentation that these 2,155 claims were processed found by OIG?
3. The fact that a huge amount of documents supposedly disappeared without a trace. Someone in management had to know what was happening with these informal claims, because no papers, especially any that could be claim-related, can be thrown away. All papers are put in boxes that are collected weekly by an employee in the document disposal department, and then the supervisor in that department examines all documents before shredding them. Knowing this policy, I find it *impossible* to believe that thousands of claims could disappear without a trace in that office.
4. The "poor recordkeeping practices" by agency management. I believe management deliberately hid the evidence of the claims involved. When we first worked on these claims, our group wrote "NAN", for No Action Needed, on those where the vet or survivor had died. At the end of the day, we gave these claims to the supervisor in the room (who I think was from the mailroom). Since they're missing, someone with authority had to allow them to be shredded.

In closing, OIG's report shows that agency management failed to treat this situation with the care and concern those veterans deserved, so I hope there will be serious consequences for those involved when this case reaches the next stage. Someone must be held accountable for the mishandling (or deliberate destruction) of these claims, because many veterans died waiting for benefits, and their families are still in the dark that this happened.

Sincerely,

Roselyn Tolliver