United States Government Accountability Office

Report to Congressional Committees

September 2020

VA POLICE

Actions Needed to Improve Data Completeness and Accuracy on Use of Force Incidents at Medical Centers

Accessible Version

GAO-20-599

GAO Highlights

Highlights of GAO-20-599, a report to congressional committees

September 2020

VA POLICE

Actions Needed to Improve Data Completeness and Accuracy on Use of Force Incidents at Medical Centers

Why GAO Did This Study

About 5,000 VA police officers are responsible for securing and protecting 138 VA medical centers across the country. These officers are authorized to investigate crimes, make arrests, and carry firearms.

The Dr. Chris Kirkpatrick Whistleblower Protection Act of 2017 included a provision that GAO assess aspects of the VA police services. This report addresses (1) what the VA's policies are on the use of force by police officers at medical centers, and what training officers receive on the use of force; (2) how VA records and investigates use of force incidents at medical centers; and (3) the extent to which VA sufficiently collects and analyzes use of force data at medical centers.

To address these objectives, GAO reviewed VA policies, procedures, and training materials on the use of force and interviewed VA officials at headquarters and six local medical centers, selected to represent varying size and locations. GAO reviewed VA data on use of force incidents recorded from May 10, 2019, through May 10, 2020—the most recent full year data were available.

What GAO Recommends

GAO is making five recommendations, including that VA improve the completeness and accuracy of its use of force data; implement a tool to analyze use of force incidents at medical centers nationwide; ensure that medical centers submit all use of force investigations to VA headquarters; and analyze the use of force investigation data. The VA concurred with each of GAO's recommendations.

View GAO-20-599. For more information, contact Gretta L. Goodwin at (202) 512-8777 or goodwing@gao.gov.

What GAO Found

The Department of Veterans Affairs' (VA) policy on use of force states that police officers must use the minimal level of force that is reasonably necessary to gain control of a situation and should only utilize physical control methods on an individual when the force is justified by the individual's actions. To guide officers, VA developed a Use of Force Continuum Scale to define and clarify the categories of force that can be used.

Categories of Force on the VA's Use of Force Continuum Scale

Source: GAO analysis of the Department of Veterans Affairs (VA) use of force policy; Art Explosion (clip art). | GAO-20-599

According to VA policy, all police officers must receive training on the VA's use of force policy when hired and biannually thereafter. Officers are trained—through classroom lectures and scenarios that emphasize effective communication techniques—to use the minimal level of force to deescalate a situation.

Officers record use of force incidents electronically and the chief of police decides which, if any, use of force incidents need to be investigated in accordance with VA guidance. Chiefs of Police at the six facilities GAO visited conducted investigations in a similar manner, by reviewing evidence and comparing an officer's action with the VA's use of force policy to determine whether actions were justified. While most investigations are conducted at the local level, VA headquarters may also run investigations for certain incidents, such as when it receives a complaint against an officer.

VA police officers record incidents in a database, Report Executive, but GAO's analysis indicates that VA data on use of force incidents are not sufficiently complete and accurate for reporting numbers or trends at medical centers nationwide. For example, GAO found that 176 out of 1,214 use of force incident reports did not include the specific type of force used. Further, Report Executive does not track incidents by individual medical centers. By addressing these limitations, VA can more effectively monitor use of force trends by type of force or medical facility, among other variables, to understand the VA's use of force incidents nationwide. GAO also found that VA does not systematically collect or analyze use of force investigation findings from local medical centers, limiting its ability to provide effective oversight. Specifically, there is no policy requiring Chiefs of Police to submit all investigations on use of force to VA headquarters, and VA does not have a database designed to collect and analyze data on use of force investigations. Collecting and analyzing such data nationwide would allow VA to better assess the impact of its deescalation policies and improve the agency's oversight efforts.

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Abbreviations

OSLE	Office of Security and Law Enforcement
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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Within the Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) manages medical centers that provide health care—including mental health services, critical care, and physical therapy—to millions of veterans. As part of providing such care, VA is expected to provide a safe environment not only for the patients but also for staff and visitors at VHA facilities. VA police are responsible for protecting and securing patients, staff, visitors, and property at each medical center.[1] VA police officers operate in a unique environment that requires balancing the treatment and care of veterans while also maintaining order and enforcing the law. For example, VA police officers might respond to incidents involving disruptive patients in emergency rooms or mental health areas that experience high levels of security incidents.

Officers are authorized to carry firearms, investigate criminal activities, and arrest individuals for offenses committed on medical center property, among other activities.[2] In some cases, officers may need to use physical force to help bring a violent or hostile situation under control. The VA Office of Inspector General—following receipt of hotline complaints and other information related to the accountability and performance of VA police at medical centers—studied the governance structure of VA police operations several years ago.[3] In December 2018, the Inspector General issued a report finding there was inadequate governance of the VA police program, including the VA headquarters' lack of monitoring police officer activities and inspection results.

[1]Approximately 5,000 VA police officers are assigned to 138 medical centers, including medical center annexes and outpatient clinics. VA police provide security and law enforcement services at VHA medical centers and Veterans Benefits Administration offices collocated at those centers, and may provide security for VA national cemeteries.

[2]38 U.S.C. § 902.

[3]The report found, among other deficiencies, that VA did not have mechanisms to systematically track and assess police operations, including arrests and investigations. Department of Veterans Affairs, Office of Inspector General, *Inadequate Governance of the VA Police Program at Medical Facilities,* Report #17-01007-01 (December 13, 2018).

The Dr. Chris Kirkpatrick Whistleblower Protection Act of 2017 included a provision that we assess the reporting, staffing, accountability, and chain of command structure of the VA police officers at medical centers.[4] This report addresses the following questions:

1. What are VA's policies on the use of force by police officers at medical centers, and what training are officers required to undergo on use of force?
2. How does VA record and investigate use of force incidents at VA medical centers?
3. To what extent does VA sufficiently collect and analyze use of force data at medical centers?

To address our first objective, we reviewed VA policies, standards, and procedures defining when, how, and to what extent officers should use force. In addition, we interviewed officials from the VA's Office of Security and Law Enforcement (OSLE) responsible for developing use of force policies to understand how the VA develops and enforces use of force policies. Further, we reviewed relevant VA training policies and requirements, lesson plans, and course materials to identify how VA police officers are trained on use of force policies. We also interviewed officials from the VA's Law Enforcement Training Center responsible for developing and delivering training, as well as VA headquarters officials, to understand the training requirements, content, and delivery methods of use of force training. In addition, we interviewed officials at a non-generalizable sample of six of 138 VA medical centers to gain the perspective of officers, management, and instructors on the effectiveness and completeness of the training officers receive on use of force.[5] To obtain a range of observations and perspectives, we selected the six medical centers based on factors such as the size of the facility, whether the facility was in an urban or rural area, and geographic location. Our findings cannot be generalized to all VA medical centers, but they do provide useful insight into how individual police departments operationalize VA headquarters policies and guidance on reporting and investigating use of force incidents at medical centers.

To address our second objective, we analyzed VA policies and procedures on how use of force incidents are reported and investigated at

[4]Pub. L. No. 115-73, § 204, 131 Stat. 1235, 1241-42.

[5]We visited VA medical centers in Augusta, Georgia; Baltimore, Maryland; Dublin, Georgia; Philadelphia, Pennsylvania; Portland, Oregon; and Seattle, Washington.

the local level and VA headquarters level. We also reviewed examples of incident reports and use of force investigations shared with us at our site visits. During our site visits to the six VA medical centers, we interviewed senior management, Chiefs of Police, and supervisory and frontline officers to understand the methods for documenting, reporting, and investigating use of force incidents at their local facilities, and what information, if any, they share with VA headquarters. In addition, we interviewed VA headquarters officials responsible for the VA's central database for reporting use of force incidents, and discussed the reporting requirements and practices. We interviewed VA headquarters officials responsible for investigating use of force incidents at both the local and headquarters levels.

To address our third objective, we assessed the VA's policies for collecting and analyzing use of force incidents and investigations, including requirements for medical centers to report these incidents and investigations. We compared them to GAO *Standards for Internal Control in the Federal Government* regarding the importance of processing quality information to make informed decisions and achieve the agency's objectives.[6] In addition, we conducted systematic data analysis on VA record-level data on use of force incidents from May 10, 2019, through May 10, 2020, the first full year that all VA medical centers were required to report incidents in the current reporting database.

To assess the reliability of the VA's use of force data, we (1) performed manual data testing of certain variables for obvious errors in accuracy and consistency, such as dates and categories of force used; (2) checked for duplicate records; (3) reviewed related documentation to understand how the data were entered; and (4) interviewed officials knowledgeable about the data to identify data challenges and limitations, if any. For example, we performed data tests on all VA records of use of force incidents involving firearms—identified as the highest use of force category on the VA's force continuum (discussed below)–-and completed logic checks for those records that listed a different level use of force than indicated on the force continuum.

Through our analysis, data testing, and interviews with officials, we identified inconsistencies with how the data were entered and recorded. Therefore, we determined that the data were not sufficiently reliable for

[6]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington D.C.: September 2014).

our intended purposes of highlighting general trends of use of force incidents by year, type of force used, or medical facility. We discuss these data limitations later in the report. Lastly, we interviewed senior management officials at VA headquarters to understand the type of information they receive from medical centers on use of force incidents and investigations that occur at the facility level and what analyses are conducted, if any, to identify trends in use of force incidents and investigations at medical centers.

We conducted this performance audit from January 2019 to September 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

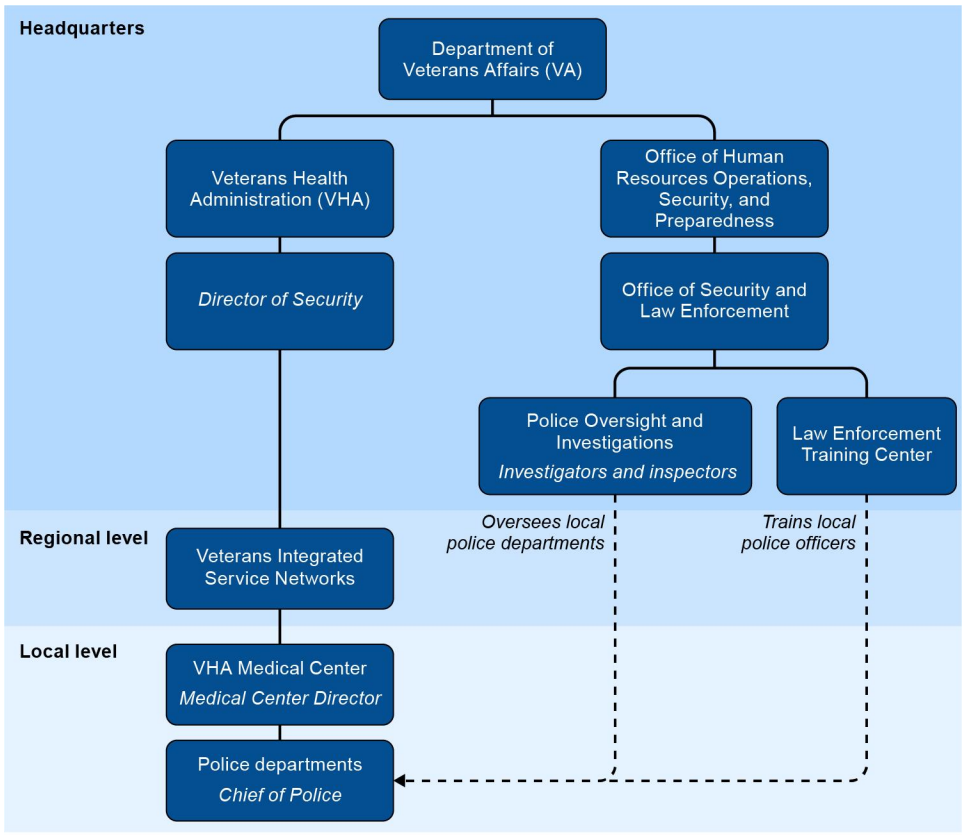
Background

VA Oversight of Police at Medical Centers

VA police have the authority to enforce federal laws on VA property, make arrests, and investigate criminal activities.[7] Oversight for the VA's police program is shared between the VHA and VA's Office of Human Resources Operations, Security, and Preparedness. Within the VHA, the Deputy Under Secretary of Health for Operations and Management is responsible for managing the police service, broken into 18 geographic regions called the Veterans Integrated Service Network. Regional Directors are responsible for managing police operations at each medical facility within their region. At the facility level, a Chief of Police and Medical Center Director are responsible for providing daily management of the police unit at their facility. Figure 1 illustrates the organizational structure and division of the VA offices with oversight responsibilities for the police program.

[7]38 U.S.C. § 902.

Figure 1: VA Offices with Oversight Responsibilities for the Police Services



Source: GAO analysis of Department of Veterans Affairs information. | GAO-20-599

Within the Office of Human Resources Operations, Security, and Preparedness, OSLE is responsible for developing policies and standards for the VHA's police services and conducting oversight and criminal investigations of medical center police units, among other responsibilities.[8] In particular, the office:

- develops and disseminates policies and procedures to medical centers on law enforcement operations, and provides technical assistance to medical center leadership and Chiefs of Police;
- conducts a biennial program inspection of each medical center's police unit to ensure they are operating according to VA policies

[8]OSLE is responsible for developing policies, procedures, and standards to support the VA's infrastructure protection and law enforcement programs, providing personal protection for the Secretary and the Deputy Secretary of Veterans Affairs, and conducting intelligence and analysis of crimes on VA property.

for police services. Oversees investigations of alleged criminal activity by police unit personnel; and

- oversees the VA's Law Enforcement Training Center—which is responsible for developing and delivering training to VA police officers.

VA Policy Requires Police Officers at Medical Centers to Use the Minimal Force Necessary, and Officers Are Trained on These Requirements

VA Requires Police Officers to Use the Minimal Force Necessary to Bring Situations Under Control

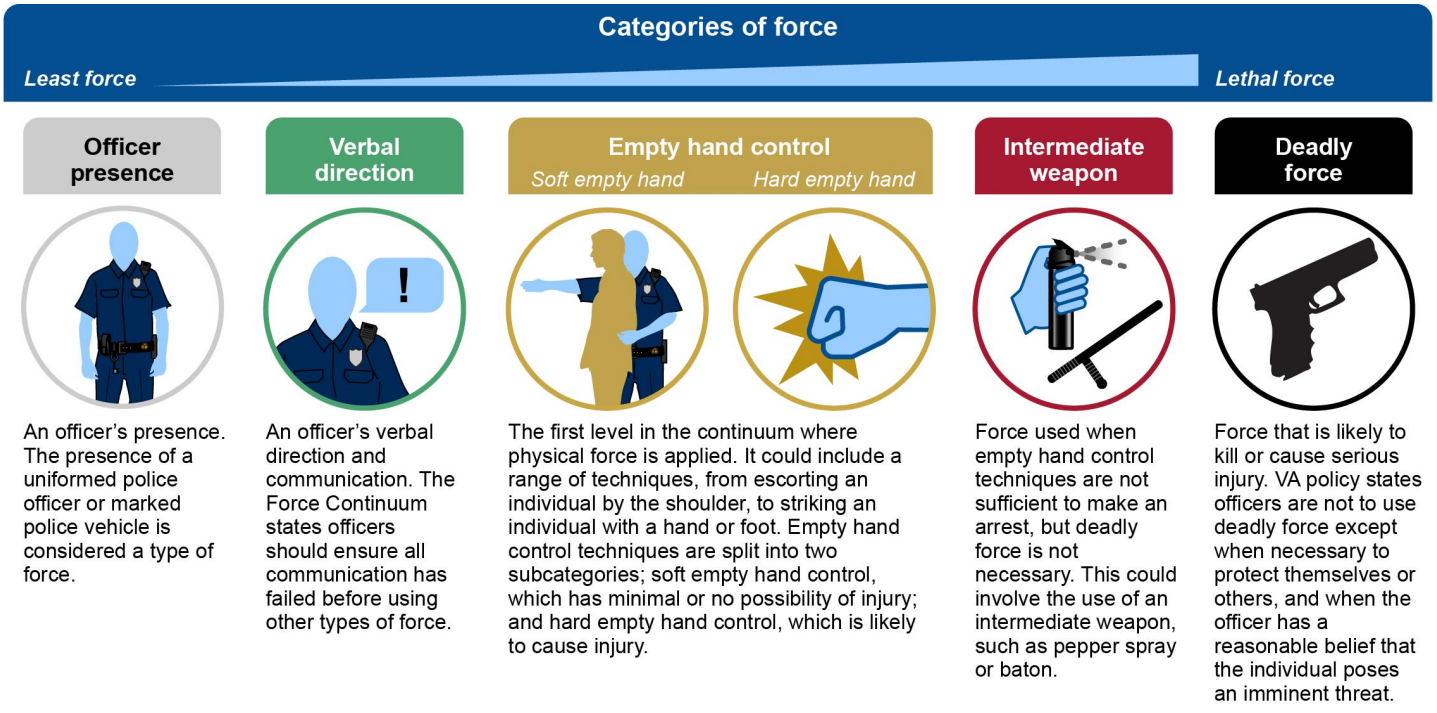
The VA's *Standard Operating Procedures on Use of Force* (2007), developed by OSLE, states that officers must use only the minimal level of force that is reasonably necessary to gain control of a situation.[9] The minimal level of force is defined as the level of force least likely to cause injury that a reasonable officer would determine is necessary to bring a situation under control. The VA's standard operating procedures state that the goal for police officers is to gain voluntary compliance from individuals. They also recognize that officers may have to use force involving physical control methods to make an arrest or bring a violent or hostile situation under control. However, the procedures state that officers should utilize physical control methods on an individual only when the force is justified by the actions of that individual. Further, officers are to use only the minimal level of force that is reasonably necessary to gain control of a situation.

VA has developed a Use of Force Continuum (force continuum) to define and clarify the level of force that can justifiably be used by an officer to gain control over a situation (see figure 2). The lowest level of force in the

[9]Department of Veterans Affairs, Office of Security and Law Enforcement, *Standard Operating Procedures*, Chapter IV, Section D (Washington, D.C.: June 2007). The use of force Standard Operating Procedures provide detailed guidance on how officers should operationalize the policies on use of force contained in VA Handbook 0720 *Procedures to Arm Department of Veterans Affairs Police* (2000). The Department of Justice determined that the VA's use of force policy is consistent with the department's 1995 guidance on the use of deadly force by federal law enforcement.

continuum is officer presence, followed by an officer's verbal direction. The next level on the continuum involves officers putting their hands on an individual—termed "empty hand control." These hand control techniques are subdivided into "soft empty hand control"—such as gently guiding an individual or grasping them—and "hard empty hand control"—such as striking an individual with a hand or foot. The fourth level on the force continuum involves the use of intermediate weapons such as pepper spray and expandable batons. According to VA's standard operating procedures, officers should generally only use physical control methods either to (a) stop potentially dangerous and unlawful behavior, (b) protect themselves or others from injury or death, (c) protect individuals from harming themselves, or (d) arrest an individual who is resisting the officer's commands. The use of a firearm—known as deadly force—is VA's highest level of force on the continuum. Officers are not allowed to use deadly force except to defend themselves or others when they deem the offending individual poses an immediate threat of death or serious injury to the officer or others.

Figure 2: The Five Categories of Force on VA's Use of Force Continuum Scale



Source: GAO analysis of the Department of Veterans Affairs (VA) use of force procedures; Art Explosion (clip art). | GAO-20-599

Note: According to VA's Standard Operating Procedures on the Use of Force, the intent for the Force Continuum scale is to provide a guide for officers when trying to control disruptive behavior. Officers are not required to use the levels of force in order from lowest to highest.

According to VA standard operating procedures on use of force, the force continuum is to be used as a guide for officer decisions but is not meant to overtly restrict officers' actions to protect themselves or others. Although officers should, according to the standard operating procedures, generally escalate their use of force one level at a time to gain control of a situation, and deescalate to the level needed to maintain control, officers are not required to start at the bottom of the continuum and move through every level of force.

The standard operating procedures state that using force beyond what is necessary under the particular circumstances is unjustified and considered to be a criminal act. To make this determination, an officer's use of force is evaluated in comparison to the force threatened or used against the officer. For example, when applying force to bring a situation under control, an officer should assess an individual's intent, opportunity, and capability of causing harm to the officer or others. An officer should also consider factors such as an individual's age, physical capabilities, and whether the individual has a weapon.

Moreover, the VA guidance on use of force recognizes that not all unjustified use of force incidents result from officer misconduct, and could be the result of an accident or an honest mistake. For example, according to officials from OSLE, an officer could be justified in using a baton to stop an individual from causing harm to the officer or others. However, if during the scuffle, the officer accidently strikes the individual in the head when intending to strike the individual in the leg, the act could be considered an unjustified use of force but could be deemed an accident.

VA Requires Police Officers to Undergo Use of Force Training When First Hired, and Biannually Thereafter

VA policy requires that all officers undergo initial training when first hired, and receive continuing training thereafter.[10] All newly hired officers are required to complete VA Police Officer Standardized Training (basic training) at the VA's Law Enforcement Training Center in North Little

[10]Department of Veterans Affairs, Office of Security and Law Enforcement, *Security and Law Enforcement Handbook*, VA Handbook 0730. (Washington, D.C.: August 2000).

Rock, Arkansas.[11] The basic training—which lasts for 10 weeks—covers a range of topics to prepare officers for conducting themselves appropriately within the unique environment at VA medical centers. Topics include the policies, procedures, and techniques surrounding use of force and officers are trained to be familiar with and apply the force continuum. For example, officers are taught verbal de-escalation, effective communication techniques, and the proper use of expandable batons, pepper spray, and firearms. Further, officers at all six facilities we visited stated that training courses stress that VA police officers are expected to prioritize verbal communication before using physical force to bring a situation under control. In addition, according to OSLE officials, the basic training program includes 14 hours on understanding how to respond to veterans with mental illness or a traumatic brain injury. Basic training courses consist of a combination of classroom lectures and practical scenarios where officers practice applying the techniques in a situation similar to what they may face in a medical center. Officers are graded on their ability to perform the techniques through their performance in scenarios, and their training records are stored in an electronic database.[12] After completing basic training, officers must certify annually that they have read and fully understand VA's use of force policies.

After completing basic training, officers are required to complete mandatory recurrent training at their local medical centers. As part of their local training, officers must complete a biannual refresher course on the VA's use of force policy and pass an online test to maintain certification. Moreover, use of force topics are incorporated into other training courses. For example, officers are required to complete courses on ground defense and recovery—covering techniques such as defending against attempts to disarm them of their duty weapon, active threat response, and use of firearms courses—each of which can include content on when and how to use force. According to officers we spoke to during our site visits, training courses may include scenario-based activities such as active

[11]This basic training program, as well as the Law Enforcement Training Center academy itself, has been evaluated and accredited through the Federal Law Enforcement Training Accreditation Office of Accreditation.

[12]According to VA officials, officers who fail an exam are provided remediation before they attempt the exam a second time. If an officer is unsuccessful after remediation, their training assignment is terminated and it is up to the Medical Center leadership and the chief of police to determine whether the officer will be allowed to attempt the training again.

threat simulators and interactive projector videos. Officers we spoke with at four of six medical centers also stated that the training on use of force they received from VA is more comprehensive than training they had received for other law enforcement jobs.[13]

The local training courses conducted at medical centers are led by officers who have been certified as trainers at the Law Enforcement Training Center. OSLE requires that these trainers recertify as an instructor every 3 years. The training instructors at each medical center, along with the chiefs of police, are responsible for ensuring all officers have completed the required training. VA policy requires that documentation for completed training be maintained in officers' training folders. OSLE's inspectors review these training completion records as part of their biennial inspection at each medical center.

VA Police Officers Record Use of Force Incidents in a Central Database, and Investigations Can Be Initiated at the Local and Headquarters Levels

VA Police Officers Must Record Their Use of Force in Daily Logs and Incident Reports

VA officers are required to complete electronic records of their daily activities, including use of force incidents, in two main ways—Daily Operations Journals and Incident Reports—which are reviewed by local chiefs of police on a daily basis. VA police must record the daily journals and incident reports in Report Executive, the VA's central database for recording a range of police activities. Officers enter information such as the type of incident that occurred, the time and location of the incident, whether there was an arrest made, and the type of force used, if any, among other information. In addition, the chief of police and other medical center leaders must also complete Serious Incident Reports to notify VA headquarters of certain high-interest police activities.

[13]During our site visit interviews, officers discussed—to varying degrees of specificity—use of force policies and training. For this example, officers in the other two facilities did not raise this point during the course of our interviews, which does not necessarily mean that they do not share this opinion.

Daily Operations Journal. All police activity at a medical center over a 24-hour period is required to be logged into the Daily Operations Journal—a chronological log of all officers' security-related activities. For example, journal entries record when an officer makes routine building checks, assists a motorist, responds to a complaint or disturbance, or makes an arrest. Either a police officer or a police dispatcher logs the journal entries electronically into Report Executive.[14] Journal entries contain brief descriptions of all calls; reports of unusual occurrences received by the police unit; and actions taken by officers, including instances where an officer used force to control an incident. In instances where an officer used force, VA procedures state that the officer is required to provide information, such as the time the call for assistance was received, a brief synopsis of the incident, the name and identification number of the responding officer, the time and location of the event, the type(s) of force used in response to the incident, and whether or not an arrest was made. Journal entries should also contain a reference to a corresponding incident report, if one is created for the incident, according to VA procedures. VA procedures also state that the chief of police must review and sign the Daily Operations Journals.

Incident report. Incident reports are the primary reporting tool for incidents occurring at VA medical centers. As soon as practicable after an incident occurs, officers are required to initiate an incident report for all complaints they receive or incidents they either observe while patrolling the premises or that are reported to them by witnesses or complainants.[15] For example, VA police officers record details of investigations into theft on VA's compound, assault complaints, and incidents where force was used to control the situation, such as controlling a disruptive patient in the mental health ward. Officers are required to record more detailed information in incident reports than they do in the Daily Operations Journal. For example, an incident report includes a description of the offender, the type of offense committed, whether a weapon was used to commit the offense, a narrative of the officer's investigation into the offense, and whether the officer used a weapon to control the situation. However, police officers are not expected to record all of their daily activities in incident reports. For instance, an officer would not be

[14]According to VA officials, a police dispatcher will record journal entries if the medical center has a designated police dispatcher on duty. However, not all facilities have police dispatchers.

[15]Department of Veterans Affairs, Office of Security and Law Enforcement, *Standard Operating Procedures*, Chapter I, Section U. (Washington, D.C.: October 2005).

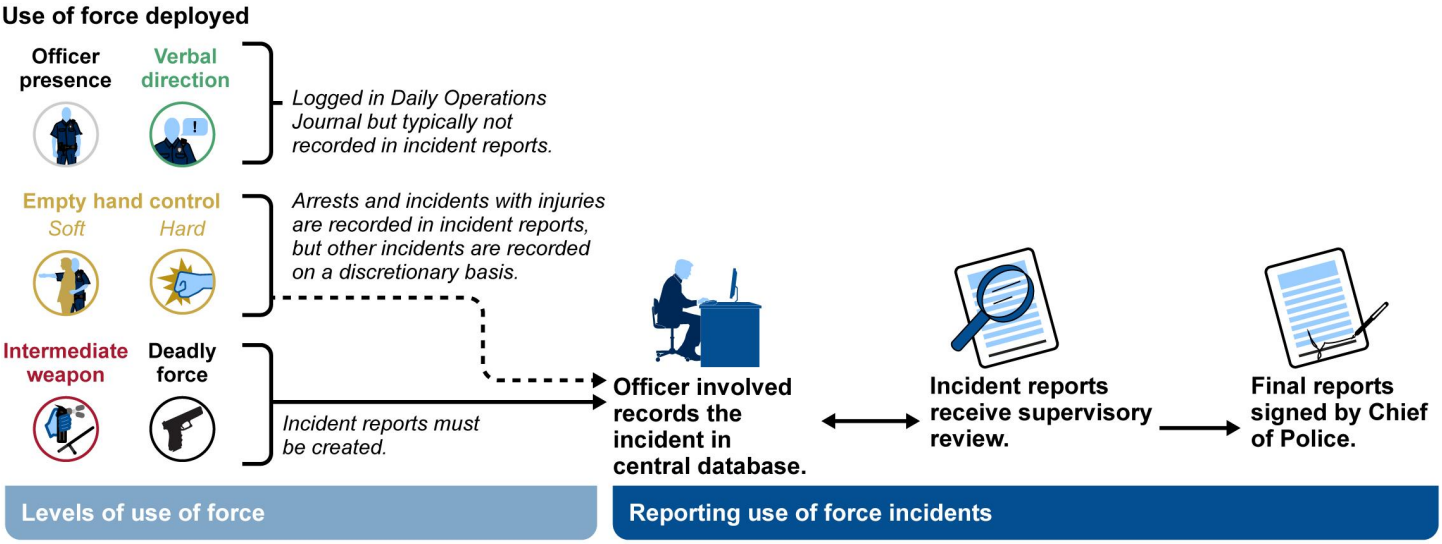
expected to complete an incident report for a routine traffic violation or other minor violation when the officer addressed the occurrence with a minor use of force, such as a verbal warning, according to VA's procedures. According to OSLE officials, officers have discretion in determining what constitutes a minor occurrence and therefore would not require an incident report.

Report Executive contains an incident report form for the officer to electronically report an incident. The form prompts the officer to select the type of force used from a drop-down menu, indicate whether the individual sustained injuries or was arrested, provide a narrative of the incident, and provide a justification for any force used to control the situation, among other information. The supervisory officer on duty at the time of the incident is required to review the incident report—or a report with an addendum, if other officers who were on the scene choose to record their version—to ensure the information is accurate.[16] Thereafter, the chief of police is to review and sign the incident report.[17] Figure 3 illustrates the types of force that, if used, officers would record in an incident report, and the review process for such reports.

[16]According to OSLE officials, when more than one officer responds to an incident, one officer is considered the primary officer responsible for filing the incident report, and the additional officers may enter follow-on reports that add their account of the incident to the original incident report.

[17]In addition to local Chiefs of Police, who review Incident Reports and Daily Operations Journals, VA headquarters officials have access to these reports in the database and told us they review Incident Reports as needed, such as when their office receives a complaint of excessive use of force.

Figure 3: Flowchart on Recording and Reviewing Use of Force Incidents by VA Police



Source: GAO analysis of Department of Veterans Affairs (VA) policies and interviews with VA officials; Art Explosion (clip art). | GAO-20-599

Note: The Daily Operations Journals are brief records of all daily police activities, including all levels of use of force activities, as well as daily routine activities. Incident reports capture the details of certain use of force incidents. VA police officers have the discretion to complete an incident report in cases where the force does not involve a weapon and when the force did not result in injuries. As a result, officers typically do not record the two lowest types of force in incident reports.

VA policy states that Chiefs of Police should notify OSLE if a use of force incident occurred that involved an intermediate weapon or firearm—the two highest categories on the Force Continuum. Specifically, the policy requires the chief of police to email an incident report to OSLE within 24 hours after the officer has completed the report. In addition, the policy states that a chief must notify OSLE of a nonweapon incident if the chief believes the officer's actions were not consistent with the VA's use of force policy.

Serious Incident Report. In addition to recording police activities, as noted above, in Report Executive, VA policy requires that police immediately notify VA headquarters of certain high-interest incidents, significant events, and critical emerging or sensitive matters that occurred

at their facilities.[18] The purpose of these reports on serious incidents is to keep the VA Secretary and other senior leaders, including OSLE, informed of events, including certain use of force incidents involving police officers. Procedures from OSLE require police officers to notify a local facility manager of incidents such as national security threats, officer shootings, or physical arrests to their managers. Immediately thereafter, the chief of police or other local facility official is required to call VA's Integrated Operations Center and to follow up by submitting a serious incident report.[19]

Local Medical Centers Primarily Conduct Use of Force Investigations, but VA Headquarters May Also Initiate Investigations

Local VA medical centers have the primary role in conducting use of force investigations and taking action against officers found to have used an unjustified level of force. Officials we spoke with at six medical centers reported that investigations are initiated by the chiefs of police to determine whether the force used was within VA policy ("justified force") or not within policy ("unjustified force"). In addition, OSLE can initiate an independent, headquarters-level investigation if it suspects a use of force incident involved criminal behavior.

Local facility investigation. VA procedures state that Chiefs of Police are to conduct use of force reviews under prescribed circumstances, such as when an officer uses an intermediate weapon or displays a firearm. In addition, all six Chiefs we spoke with said that they may also initiate investigations for other types of force that caused injury to an individual or for complaints about any incident involving an officer filed by a victim,

[18]VA guidance requires medical center management to submit Serious Incident Reports for the following incidents that occur on facility grounds when (a) an officer is injured, (b) police officers employ a weapon against an individual,(c) a serious injury or a suspicious or wrongful death occurs, (d) an aggravated assault or sexual assault occurs, (e) a felony occurs, (f) a patient is missing, (g) a physical arrest is made, (h) a suicide (or attempted suicide) occurs, (i) a bomb threat is made, (k) a fire or disaster occurs in or within close proximity of VA property, or (l) any other incident considered significant or sensitive in nature occurs.

[19]Within VA, serious incident reports are sent to the Integrated Operations Center, VA's national information sharing hub for crisis management, operational coordination, and disaster response. The center operates 24/7, with staff representing all administrative offices, including OSLE.

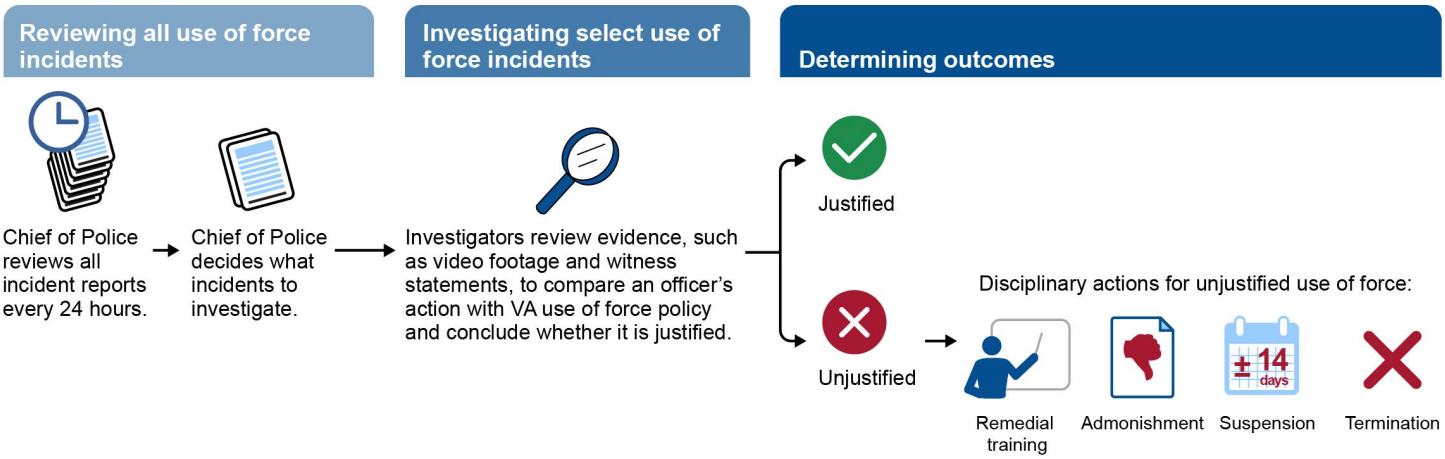
staff, or witness to the facilities' complaint board, the Medical Director, or other senior leaders at the facility.

According to four of six Chiefs, they initiate investigations after examining all use of force incidents reported over the previous 24-hour cycle.[20] Chiefs of Police we spoke with stated that they typically initiated use of force investigations if they had questions about the circumstances surrounding an incident or if the officer appears to have acted out of compliance with policy. For instance, Chiefs we spoke with told us they have initiated investigations when an officer injured an individual with a weapon or drew a firearm. At one facility, for example, the chief initiated an investigation when an officer drew his firearm on an individual walking around an empty parking lot with a syringe. According to the chief, he believed the officer may have acted outside of policy, since an officer is not permitted to use deadly force against any person except when it is necessary in self-defense or the defense of another. In this case, the chief questioned whether the individual with the syringe posed an imminent threat and decided to open an investigation to determine if the officer was in compliance with policy. The officer who drew his gun at the individual with the syringe was found to have used unjustified force because the officer was not in immediate danger and other techniques were available for the officer to deescalate the situation. The investigators arrived at this conclusion after reviewing video evidence and witness statements.

VA guidance allows Chiefs to determine the specific process for investigating use of force incidents, and we found similarities in the processes among the facilities we visited. Each of the six facilities we visited conducted use of force investigations in a similar manner—typically tasking local certified training instructors to compare an officer's actions against the VA's use of force policy and training, and to provide an informed assessment based on their knowledge of the policy for the chief's consideration. Figure 4 summarizes the local investigation process—based on our interviews with medical center Chiefs of Police—along with several options for disciplinary actions if the investigation determines that the officer in question breached the VA's use of force policy.

[20]In addition to reviewing police reports, Chiefs of Police may review the Daily Operations Journal to identify incidents that warrant investigations. According to four of six Chiefs, they may also become aware of incidents in real time, when officers verbally inform them via a phone call or email prior to filing an incident report.

Figure 4: Investigation Process for Use of Force Incidents at VA Medical Centers



Source: GAO analysis of Department of Veterans Affairs (VA) policies and interviews with VA officials. | GAO-20-599

Note: If an officer is found to have violated the VA's use of force policy, the options for disciplinary action vary, based on severity of the offense. The local medical center leadership, along with the Human Resources Department, makes the final determination on disciplinary actions.

The local investigation may involve the chief, deputy chief, and other appointed investigators, such as local officers who have been certified as use of force instructors by the VA's Law Enforcement Training Center. The use of force procedures instructs investigators to compare the force used, or threatened, by the perpetrator—taking into account the intent, opportunity, and capability to cause harm—with the force employed by the officer. In addition, officials we spoke with at all six VA medical centers told us that investigators review all available evidence—such as video footage and statements from those who were involved or witnessed the incident—to determine whether the officer under review was justified in the actions taken. The investigators submit their conclusion—whether the level of force was justified or unjustified—to the chief of police for review.[21]

[21]The chief of police has the discretion to contact the Veterans Integrated Service Network, Law Enforcement Training Center, or OSLE in VA headquarters for assistance with a local investigation or to obtain a second opinion on an investigation. The chief may use this resource if the chief disagrees with the findings of the local investigators or if the chief has questions regarding a case. The assistance is typically informal, via phone call or email. Additionally, the medical director may also contact these offices to request an independent investigation, if the actions of the chief are suspected to be inconsistent with VA policy.

Officials from four of the six medical centers we visited reported that use of force investigations occur infrequently and that most arrive at the conclusion that force was justified.[22] For instance, one Chief estimated that the facility had conducted approximately 15 use of force investigations over a 20-year period and that all but one were the result of empty hand control incidents; one investigation focused on the use of a weapon. At another facility, an officer reported participating in approximately 10 use of force investigations since 2015. Of these investigations, the officer noted that eight concluded that force was justified.

VA medical centers also have the primary role in taking disciplinary actions against officers determined to have used unjustified force. After an investigation is complete, the chief of police uses the results from the investigation to help determine whether a disciplinary action is warranted and, if so, makes a recommendation on the type of action.[23] The range of actions, in order of severity, include:

- remedial training,
- admonishment,[24]
- suspension,
- reduction in pay or grade, and
- termination.

According to the officials from all six facilities we visited, the Chief then sends the investigation's results and disciplinary recommendation to the local medical center leadership, including the Medical Center Director. In addition, Chiefs are to send a copy of the investigation results to OSLE,

[22]During our site visit interviews, some officers raised to us use of force investigation trends and examples. Officers in the other two facilities did not raise the trends during the course of our interviews, which does not necessarily mean that use of force investigations are more frequent at these facilities.

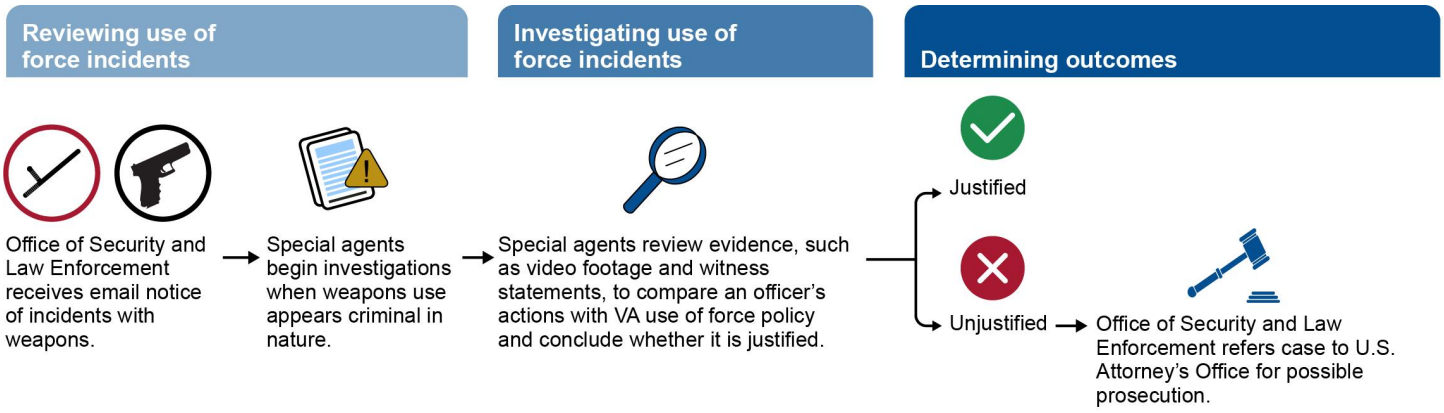
[23]Officials at all six facilities we visited told us that officers have the right to request representation by a union representative at any point during or after an investigation, in accordance with Weingarten Rights – the right of the employee to have union representation during investigative interviews. Officers may also request representation to appeal the recommended disciplinary action.

[24]An admonishment is a written statement of censure given to an employee for a minor act of misconduct. An admonishment is delivered through an official letter to the employee describing the reasons for the action.

according to VA guidance. However, OSLE officials told us information on use of force investigations is not stored in the Report Executive database—discussed further below. The local medical center leadership is responsible for making the final determination on disciplinary actions with other administrative departments, such as the VA's Human Resources Department and the General Counsel providing guidance, if required. For terminations, however, the Medical Center Director makes this final decision. The Chief maintains a record of the investigation and disciplinary action(s) taken in the officer's administrative file for 3 years. The VA's Human Resources Department maintains a record of the disciplinary action taken for 2 or more years, depending on the severity of the action.[25]

VA Headquarters investigation. OSLE may initiate its own headquarters-level investigations into officers' actions—primarily involving the use of weapons—when it determines from a preliminary assessment that the case could entail criminal behavior. Figure 5 summarizes the office's investigation process.

Figure 5: Investigation Process Used by VA Headquarters for Use of Force Incidents Involving Weapons



Source: GAO analysis of Department of Veterans Affairs (VA) policies and interviews with VA officials. | GAO-20-599

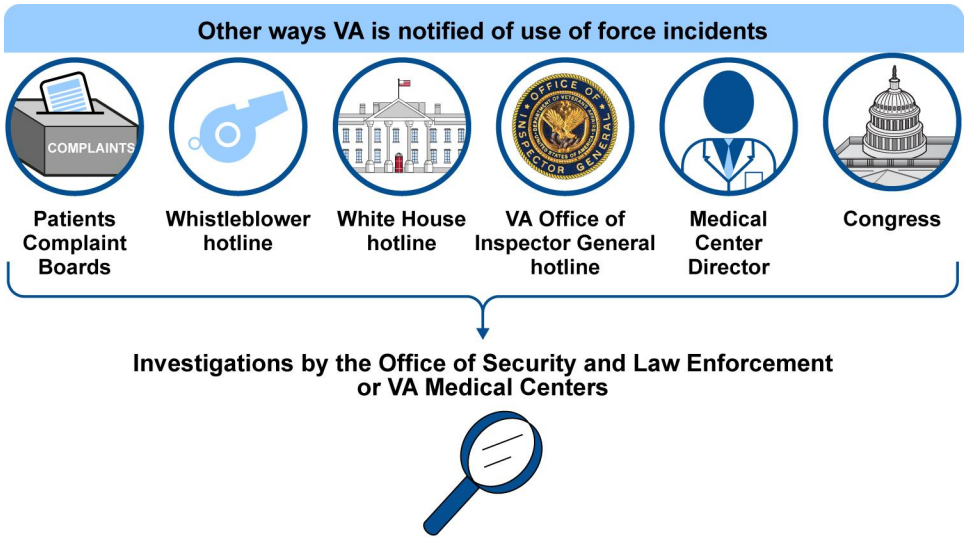
When OSLE receives a notification of an incident involving the use of an intermediate weapon or firearm from a chief of police, officials review the incident details to determine whether an investigation is warranted. Special Agents from OSLE conduct these headquarter-led investigations to determine whether the force used was justified or unjustified according

[25]For instance, a disciplinary action, such as an admonishment, is removed from an officer's personnel file after 2 years. More severe actions, such as a suspension of more than 14 days, are removed after 5 years, according to the VA's record retention guidance.

to the use of force policy. Similar to the criteria used by medical centers during a local investigation, Special Agents are to review evidence—including video footage and witness statements. Also, the agents may conduct their own interviews and review other documentary evidence to further their investigation. VA officials indicated that the vast majority of their investigations concluded that the use of force was justified. If the Special Agents determine an officer's conduct was unjustified and appears excessive or criminal, they are to refer the case to the U.S. Attorney's Office for indictment. VA officials stated they maintain records of the headquarters-level use of force investigations for 3 years.

Additionally, as summarized in figure 6, VA officials will initiate an investigation for complaints they receive from the several sources available for veterans, visitors, and staff to report use of force incidents, including the Patients Complaint Board, the VA's Office of Inspector General, or White House hotlines, or through a Member of Congress. According to VA officials, if OSLE opens an investigation into an officer's actions, the office notifies local investigators to discontinue their investigation to prevent overlap in a federal investigation.

Figure 6: Sources Other Than a Police Officer for Notifying VA of a Use of Force Incident



Source: GAO analysis of interviews with Department of Veterans Affairs (VA) officials; Art Explosion (clip art). | GAO-20-599

VA Does Not Have a Sufficient Approach to Collecting and Analyzing Use of Force Data at Medical Centers

For two broad reasons, VA does not have a sufficient approach to collecting and analyzing use of force data at medical centers. First, VA collects data on use of force incidents in Report Executive, but our analysis indicates that the data are not sufficiently complete or accurate for reporting numbers or trends about incidents across all medical centers. Second, we found that VA does not systematically collect or analyze use of force investigation findings from local medical centers. As a result, VA is hindered in its ability to oversee officers' use of force across medical centers.

The VA's Data on Use of Force Incidents at Medical Centers Are Not Sufficiently Complete or Accurate, Due to Limitations in Its Reporting Database

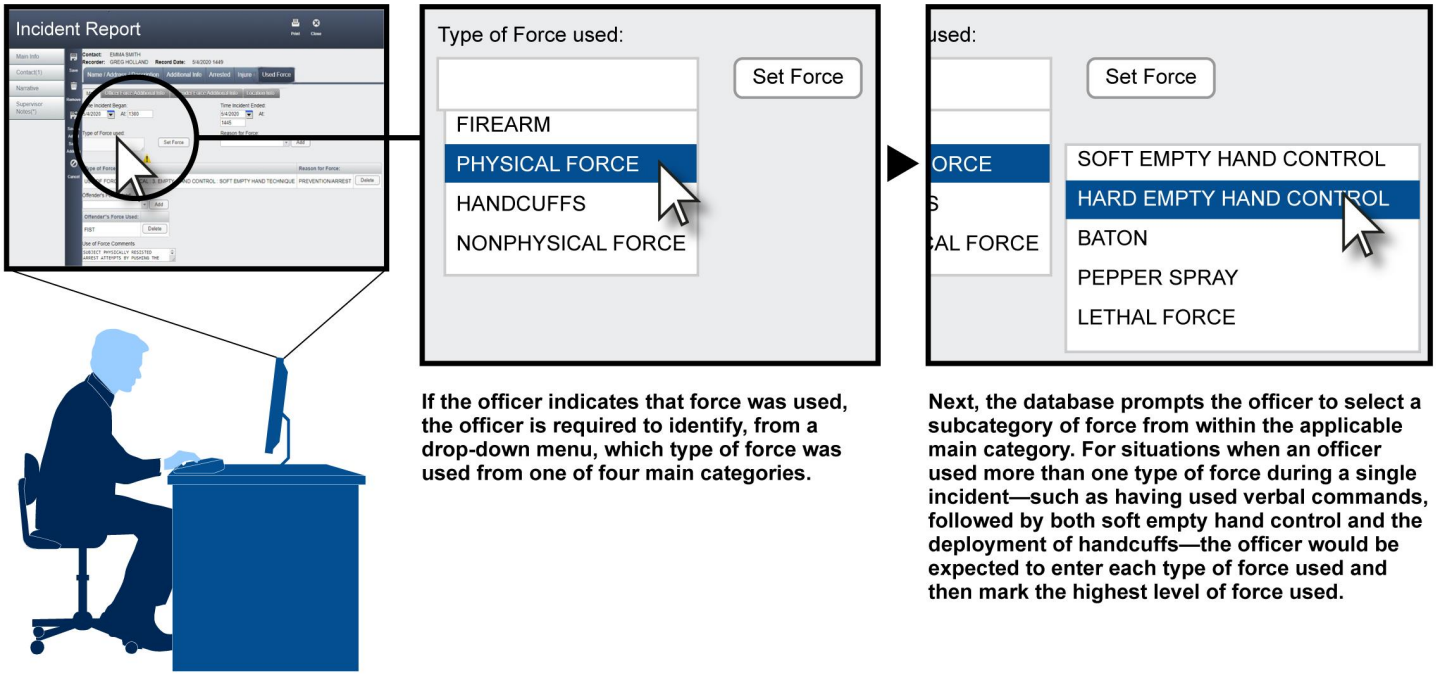
Our analysis indicates that the VA's use of force data in Report Executive may not be sufficiently complete or accurate for VA headquarters officials to develop basic descriptive statistics, such as the number of use of force incidents by date and types of force used. Specifically, we analyzed data from Report Executive on all 1,214 use of force incidents recorded from May 10, 2019, through May 10, 2020, to determine the type, frequency, and location of use of force at VA medical centers.[26] On the basis of our analysis, we identified three types of data issues in the use of force data in Report Executive: (1) incomplete categorization of the type of force used, (2) inaccurate data on the highest level of force used, and (3) the potential for duplicate data entries.

Incomplete entries of type of force used. We identified incomplete categorization of use of force entries in Report Executive. Specifically, as

[26]VA officials stated that the procurement process for obtaining Report Executive began in 2015. According to officials, VA has experienced challenges in working with the vendor to successfully implement Report Executive at medical centers. All VA medical centers began using Report Executive to log Incident Reports starting the first week of May 2019. Prior to that time, some facilities were still using the previous reporting system, called the VA Police System, to record incidents. According to officials, data from the VA's Police System are in the process of being converted into Report Executive, where it will be accessible in the new system.

illustrated in figure 7, an officer is required to check a box in Report Executive to indicate that force was used to control a situation, in accordance with VA guidance. If the officer indicates that force was used, the officer is required to identify, from a drop-down menu, which type of force was used from one of four main categories—firearm, physical force, handcuffs, or nonphysical force. Next, the database prompts the officer to select a subcategory of force from within the applicable main category (the handcuff category does not contain a subcategory). For example, if the officer selects physical force, the officer would then choose one of five types of physical force used during the incident: soft-empty hand control, hard-empty hand control, baton, pepper spray, or lethal force. For situations when an officer used more than one type of force during a single incident—such as having used verbal commands, followed by both soft-empty hand control and the deployment of handcuffs—the officer would be expected to enter each type of force used and then mark the highest level of force used.

Figure 7: VA Police Officers Categorize the Type of Force Used When Creating an Incident Report



Source: Department of Veterans Affairs (VA) guidance and interviews with VA officials; Art Explosion (clip art). | GAO-20-599

Note: Handcuffs does not have subcategories; firearm subcategories are firearm drawn and discharged; non-physical subcategories are officer presence, verbal de-escalation, and verbalization.

Of the 1,214 records we reviewed, we found that 176 records (about 14 percent) had incomplete data entries. For example, in 15 of the reports, the reporting officers indicated that force was used (i.e., the top-level box was chosen), but there was no main category of force indicated. Further, among the remaining 161 reports, the most specific subcategory of force was not indicated:[27]

- One hundred and fifteen records indicated an empty-hand control technique was used but did not specify “soft” or “hard” hand control;
- Thirty records indicated that physical force was used but did not specify one of the five specific types of physical force;
- Seven records indicated nonphysical force was used but did not include whether the force was verbal direction or officer presence;
- Six records indicated less lethal force was used but did not specify whether a baton or pepper spray was used; and
- Three records indicated a firearm was used but did not indicate whether the firearm was only drawn or actually discharged.

We discussed the results of our analyses with VA officials. They stated that these inconsistencies could be the result of officers incorrectly entering the type of force used. They suggested that such errors could be minimized if the database was modified to prompt officers to complete use of force entries with the appropriate categories and subcategories. Specifically, they noted that Report Executive, as designed, does not contain certain logic checks, for example, that would prevent officers from

[27]The data we analyzed included records for two categories of force—”empty hand control” and “less lethal force”—that were not listed as options for officers to select in the Report Executive drop-down menu. VA officials stated that these use of force categories were used previously, but the categories have since been updated and no longer include these options for officers to select from.

moving to the next section of the Incident Report template if the officer has not first selected the specific type of force used.[28]

Inaccurate data on highest level use of force. Our analysis also indicates that records in Report Executive did not always identify the highest level of force used, consistent with the VA's use of force continuum. For example, we identified 74 of the 1,214 records where officers reported drawing or discharging a firearm—the highest level use of force on the VA's force continuum. However, in 18 of these incidents, officers identified the highest-level use of force as something other than a firearm. For instance, in 11 of the incidents involving a firearm, officers indicated deploying handcuffs was the highest level of force used instead of firearms. A VA official responsible for analyzing the Report Executive data told us the data field listing the highest level of force used was not intended to align with the force continuum—rather officers were to select the use of force listed first in alphabetical order. As such, conducting data analysis on the highest level of force used by officers to control incidents during this period would be misleading and incongruent with the VA's force continuum.

Duplicate records. Lastly, our analysis indicates that in some limited circumstances, the same use of force incident appears to have been recorded more than once in Report Executive. Specifically, out of the 74 use of force incidents involving firearms we identified three instances of multiple records with the same reporting officer, date, time, and incident type. We showed an example of one of the three instances we found to VA officials responsible for analyzing the data. The officials reviewed the Incident Reports that the data were pulled from but told us they could not determine whether the records indicated separate incidents or whether the same use of force incident was counted more than once.

We discussed the results of our analyses and the database challenges with VA officials. They stated that Report Executive is an off-the-shelf police reporting system that must be configured to accommodate the VA's

[28]In June 2020, the VA's Office of Inspector General reported that VA did not have a reliably performing police information system and did not have an effective strategy to update the system. The report recommended, among other steps, that VA evaluate whether Report Executive meets the needs of VA police and to develop and implement a plan to resolve issues with the system. VA concurred with this recommendation and noted plans to assign an Integrated Project Team to evaluate whether the Report Executive system meets the needs of the VA police. Department of Veterans Affairs, Office of Inspector General, *VA Police Information Management System Needs Improvement,* Report #19-05798-107 (Washington, D.C.: June 17, 2020).

unique reporting requirements. They also stated that implementing logic checks would be beneficial to ensure more complete data entries, and stated they plan to work with the vendor to make these changes, as well as other modifications to address the other database limitations we identified. Further, VA officials told us that the system is used for the purpose of documenting Incident Reports and police activities and is not designed to allow VA to conduct comprehensive analyses on use of force incidents across all medical centers. For example, officials stated that Report Executive does not allow them to analyze use of force incidents by individual medical centers or geographic region because VA has not incorporated this reporting capability into Report Executive. Such information would be useful, according to VA officials, for understanding the frequency and nature of use of force incidents across VA medical facilities.

In order to conduct more robust data analysis, VA officials told us that, as of June 2020, they have plans to work with a vendor to implement an analytical tool into Report Executive that will allow them to record and analyze use of force incidents by facility, among other variables. However, these officials could not provide a written plan or other documentation indicating how or when VA would complete such actions.

According to the VA's *2018-2024 Strategic Plan*, a management objective involves institutionalizing data-supported decision-making that improves the quality of the agency's outcomes.[29] The agency aims to use consistent, accessible, and comprehensive data to conduct analysis to inform the improvement of outcomes for veteran services. Similarly, the *Standards for Internal Control in the Federal Government* states that agency managers should use quality information to support internal control activities because reliable information is vital for the agency to achieve its mission and objectives.[30] In doing so, managers should design systems to obtain, store, and analyze reliable information in accordance with the agency's objectives. Improving Report Executive to reduce the possibility for user errors would help the VA ensure that it has complete and accurate data on the type and level of force used at medical centers nationwide. In addition, implementing fuller analytical features within Report Executive would better position VA officials to more effectively monitor use of force trends by type of force and medical facility to

[29]Department of Veterans Affairs, *FY 2018 – 2024 Strategic Plan*. (Washington, D.C.: refreshed May 31, 2019).

[30]GAO-14-704G

understand the frequency and nature of use of force at medical centers nationwide.

VA Does Not Systematically Collect and Analyze Local Investigation Outcomes

VA headquarters does not systematically collect or analyze the findings of local medical center use of force investigations. VHA and OSLE officials stated that they cannot be certain they are notified of the findings of all local medical center investigations of use of force incidents. Specifically, when local investigators conclude whether an officer's use of force was justified or unjustified, Chiefs of Police may email these findings to various VA offices, including the VHA or OSLE. However, VHA—the entity responsible for overseeing police activities at medical centers—does not have a policy requiring Chiefs to notify VHA of the findings of their investigations. VHA officials told us that, in practice, Chiefs typically share copies of use of force investigation findings and disciplinary outcomes with their office via email, but officials could not be assured that they receive all investigation results. In contrast, Chiefs of Police are required by policy to notify OSLE—whose responsibilities are limited to developing and issuing national policies and inspecting police programs—of use of force investigations involving intermediate weapons and firearms. However, OSLE officials stated they may not receive information on all local use of force investigations, especially those involving non-weapon-related incidents and that the Report Executive database does not contain data on the findings or outcomes of use of force investigations. Only one of the six chiefs of police we interviewed said he notified both VHA and OSLE of their local investigations and another Chief said he notified neither office. The remaining four chiefs told us they notify OSLE and other VA offices.

According to VHA officials, as of June 2020, their office has plans to draft new policies requiring Chiefs to notify VHA of all local use of force investigations and resulting disciplinary action. VHA officials stated, moreover, that VA is in the process of reorganizing the roles and responsibilities of the offices that will be in charge of police oversight.[31]

[31]On October 25, 2019, VA issued a press release that announced VA's plan to realign its police operation to promote oversight and standardization. According to the press release, VA will create a police modernization office specifically chartered to (a) develop and implement uniform standards, (b) address staffing challenges, and (c) implement a police national governance body that will incorporate all department stakeholders to manage and oversee policy issues.

OSLE officials stated that the VA's plans for reorganizing police oversight would seek to address the collection of more complete data on use of force investigations. However, VA officials could not provide a written plan or a date by which the agency will implement such policy changes.

In addition, neither VHA nor OSLE systematically track or analyze the outcomes of local use of force investigations across all medical centers, including the disciplinary actions taken if an officer acted outside of the VA's use of force policy. VHA officials told us they do not conduct analyses on the data they receive from local facilities because they do not have an appropriate information system to systematically collect information from local facilities to support such analyses. Similarly, officials from OSLE told us that they do not systematically track or analyze locally-initiated use of force investigations they receive because Report Executive is not configured to record use of force investigations or capture information on whether an incident led to an investigation at the local facility level.[32]

A senior official told us that, as of June 2020, VHA is considering procuring a database that would, among other capacities, capture data on police use of force investigations across medical centers, including the results of those investigations, and tracking any disciplinary action taken.[33] However, VHA could not provide any documentation of such plans indicating how VA would complete such actions. OSLE officials stated that while use of force investigations are completed and documented by individual facilities and that disciplinary actions are the responsibility of the local leadership, having information on all use of force investigations would help them ensure that all centers are complying with the use of force procedures, and doing so in a consistent manner.

As noted above, the VA's *2018-2024 Strategic Plan* involves institutionalizing data-supported decision-making by using consistent,

[32]Officials from OSLE told us that they record and analyze the outcomes of their own headquarters-initiated criminal investigations involving excessive actions taken by police officers.

[33]The officials stated that police officers must adhere to the same code of conduct as other VA employees. We recommended in 2018 that VA develop and implement guidance to collect complete and reliable misconduct and associated disciplinary action data department-wide. As of March 2020, VA has efforts under way to address our recommendation. See GAO, *Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability*, GAO-18-137 (Washington, D.C.: July 19, 2018).

accessible, and comprehensive data to conduct analysis to inform the improvement of outcomes for veteran services.[34] Similarly, the *Standards for Internal Control in the Federal Government* instructs managers to maintain appropriate records of agency activities and to process these data into quality information to make informed decisions and evaluate their performance in achieving key objectives and oversight responsibilities.[35] Furthermore, these standards instruct managers to communicate such quality information to relevant personnel to ensure the achieving of key objectives, addressing risks, and supporting the internal control system. Systematically recording and analyzing the findings and results of all use of force investigations would help VA headquarters monitor trends and tendencies on how force is used and evaluated across medical centers and ensure that all centers are consistently applying the VA's use of force procedures. In addition, implementing a quality database to collect and analyze the results of local use of force investigations could help VA to monitor the extent to which officers' use of force incidents lead to investigations; report the frequency of use of force investigations nationwide by facility or individual officers; track investigation trends over time or review the proportion of investigations that lead to disciplinary action; and ensure that disciplinary actions across medical centers are consistent, among other things.

Conclusions

VA medical centers are secured by VA police officers who must maintain order while being cognizant of the sensitive environment in which they operate. VA police officers may encounter disruptive incidents at medical centers that require officers to deploy some level of force to control the situation. Through its policies and training, VA establishes the importance of officers using the least amount of force to control such disturbances and protect the health and safety of veterans, staff, and visitors. Although VA collects some data on use of force incidents at medical centers, improving Report Executive would help VA ensure that it has complete and accurate data on use of force activities across all medical centers. In addition, implementing analytical tools in Report Executive can help VA officials more effectively monitor use of force trends by type of force or medical facility, among other variables, to understand the frequency and nature of use of force incidents at medical centers nationwide. In cases

[34]Department of Veterans Affairs, *FY 2018 – 2024 Strategic Plan*.

[35]GAO-14-704G.

where officers' actions warrant further local investigation by the chief of police, recording and analyzing the findings and results of use of force investigations would help VA to monitor trends and tendencies on how force is used and evaluated across medical centers and ensure that all centers are consistently applying the VA's use of force procedures. Addressing database limitations would help VA conduct useful data analysis to better assess the impact of its de-escalation policies and improve the agency's oversight efforts.

Recommendations for Executive Action:

We are making the following five recommendations to VA.

- The Secretary of VA should improve the completeness and accuracy of use of force data in Report Executive by addressing (1) incomplete categorization of the type of force used, (2) inaccurate data on the highest level of force used, and (3) the potential for duplicate data entries. (Recommendation 1)
- The Secretary of VA should implement plans to include analytical features in Report Executive that will position the agency to analyze use of force data at VA medical centers nationwide, including by officer; type of force used; and facility, among other variables. (Recommendation 2)
- The Secretary of VA should ensure that medical centers submit records of all locally initiated use of force investigations and any resulting disciplinary action to VA headquarters office(s) with responsibility for police oversight. (Recommendation 3)
- The Secretary of VA should implement plans for obtaining a quality database to collect all locally initiated use of force investigations at medical centers. (Recommendation 4)
- Once positioned to do so, the Secretary of VA should analyze all use of force investigations and any resulting disciplinary action by facility; officer; and outcome, among other variables. (Recommendation 5)

Agency Comments and our Evaluation

We provided a draft of this report to VA for review and comment. VA provided written comments which are reproduced in appendix I. In its

comments, VA concurred with our recommendations and described actions planned to address them. We will continue to monitor the VA's progress in these areas.

Regarding improving the completeness and accuracy of use of force data in Report Executive, VA plans to modify the database to prompt officers to complete use of force entries with the appropriate categories of force used before being allowed to move on to the next report section. In addition, the agency revised the use of force drop down menu to list use of force in ascending order from the lowest level of force to the highest level of force used to better align with the VA use of force continuum and to help alleviate officer error when selecting the highest use of force. Finally, VA plans to place more emphasis on training officers how to use Report Executive, and reviews of the report entries by facility level police leadership.

Regarding implementing plans to include analytical features in Report Executive, VA plans to work with the vendor to add features such as a function to sort and collect use of force data by region.

With regard to ensuring that medical centers submit records of all locally initiated use of force investigations and any resulting disciplinary actions to VA headquarters, OSLE plans to work with VHA to create a process to share the results of disciplinary actions taken against VA police officers with regard to use of force matters.

Regarding obtaining a quality database to collect all locally initiated use of force investigations at medical centers, and then analyzing that data, VA stated that OSLE and VHA will work together to identify and obtain a suitable database to track and analyze investigative data. Once a database is obtained, VA stated that OSLE will analyze the use of force data and report the results to senior VA leadership.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-8777 or goodwing@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Gretta L. Goodwin
Director, Homeland Security and Justice

List of Committees:

The Honorable Ron Johnson
Chairman
The Honorable Gary C. Peters
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Jerry Moran
Chairman
The Honorable Jon Tester
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Carolyn B. Maloney
Chairwoman
The Honorable James Comer
Ranking Member
Committee on Oversight and Reform
House of Representatives

The Honorable Mark Takano
Chairman
The Honorable Phil Roe
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

August 21, 2020

Ms. Gretta L. Goodwin
Director
Homeland Security and Justice
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Goodwin:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report entitled ***VA POLICE: Actions Needed To Improve Data Completeness And Accuracy On Use Of Force Incidents At Medical Centers*** (GAO-20-599).

The enclosure contains general comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on the draft report.

Sincerely,

Brooks D. Tucker

Brooks D. Tucker
Acting Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs' (VA) Response to
Government Accountability Office (GAO) Draft Report
VA POLICE: Actions Needed to Improve Data Completeness and Accuracy on Use of Force Incidents at Medical Centers
(GAO-20-599)

Recommendation 1: The Secretary of the VA should improve the completeness and accuracy of use of force data in Report Executive by addressing (1) incompleteness categorization of the type of force used, (2) inaccurate data on the highest level of force used, and (3) the potential for duplicate data entries.

VA Response: Concur.

1. **Incomplete categorization of the type of force used** – Database is being modified to prompt officers to complete use of force (UoF) entries with the appropriate categories and subcategories. Logic checks will be incorporated into the software that prompt the officer to complete the type of force used before being allowed to move on to the next section.

2. **Inaccurate data on the highest level of force used** – UoF drop down options were re-evaluated and revised based on the feedback from GAO. The revision was completed using the current VA Police UoF policy and listed in ascending order from lowest level of force used to the highest level of force used. The options were revised to help alleviate officer error when selecting the correct UoF option used. Revising the use of force options will allow the officer completing the incident report involving UoF a more accurate choice of the action taken. This will increase the integrity and trust of the data being pulled regarding UoF incidents.

3. **The potential for duplicate data entries** – The potential for duplicate entries can be reduced by ensuring the proper steps are being followed during the report review process at the station level. Each station currently has incident report review levels in place allowing first line supervisors and second level police management to review and ensure accuracy of an officer's report entries before the report is approved and archived. The incident numbers are generated automatically for each station. Once a number is assigned, that number cannot be issued for a different report. Follow-up reports can be generated but the follow-up report number is appended with a sequential number to alleviate duplicate reports as well.

In order to improve the quality of data, more emphasis will be placed on Report Executive training and comprehensive reviews conducted by facility level police leadership. This will be validated during the program inspections.

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Enclosure

Recommendation 2: The Secretary of the VA should implement plans to include analytical features in Report Executive that will position the agency to analyze use of force data at VA medical centers nationwide, including by officer, type of force used, and facility, among other variables.

VA Response: Concur. Report Executive currently possesses the analytical features and analytical tools that allow entered UoF data, as well as other incident data, to be analyzed by officer, type of force used, facility and other variables. The features also allow the data to be analyzed for comparisons using date ranges, days of the week and also allows for comparison of the same timeframe from one year to the next for resource planning. Additional program capabilities are being developed by the vendor to allow for future system growth, such as adding a "tab" to sort and collect data by region/Veterans Integrated System Network.

Recommendation 3: The Secretary of the VA should ensure medical centers submit records of all locally initiated used of force investigations and any resulting disciplinary action to VA headquarters office(s) with responsibility for police oversight.

VA Response: Concur. The Office of Human Resources and Administration/Office of Operations, Security and Preparedness (HRA/OSP) Office of Security and Law Enforcement will work with the Veterans Health Administration (VHA) to establish a process to ensure the results of disciplinary action taken against VA Police Officers, pertaining to UoF matters, are forwarded to VA headquarters office(s) with responsibility for police oversight.

Recommendation 4: The Secretary of the VA should implement plans for obtaining a quality database to collect all locally initiated use of force investigation at medical centers.

VA Response: Concur. HRA/OSP's Office of Security and Law Enforcement will work with VHA to identify and obtain a suitable database capable of tracking and analyzing investigative data.

Recommendation 5: Once positioned to do so, the Secretary of the VA should analyze all use of force investigations and any resulting disciplinary action by facility, officer, and outcome, among other variables.

VA Response: Concur. Once a suitable database is obtained, either by programming improvements to Report Executive or by obtaining a new product, it will be used to track UoF incidents. HRA/OSP's Office of Security and Law Enforcement will analyze the data and provide appropriate reports to senior VA leadership.

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Enclosure

General Comments:

VHA intends to collaborate with VA's Office of Security and Preparedness to establish processes to monitor UoF incidents using data based solutions. Policy will be implemented to ensure there is accountability for UoF incidents that violate rules or procedures guiding VA police officer authority to use force.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Gretta L. Goodwin, (202) 512-8777 or goodwing@gao.gov

Staff Acknowledgments

In addition to the contact named above, Brett Fallavollita (Assistant Director), Brendan Kretzschmar (Analyst-in-Charge) and Dainia Lawes made key contributions to this report. Willie Commons III, Dominick Dale, Elizabeth Dretsch, Eric Hauswirth, Susan Hsu, and Britney Tsao also contributed to this report.

Appendix III: Accessible Data

Agency Comment Letter

Accessible Text for Appendix I Comments from the Department of Veterans Affairs

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August 21, 2020

Ms. Gretta L. Goodwin Director

Homeland Security and Justice

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

Dear Ms. Goodwin:

The Department of Veterans Affairs 01A) has reviewed the Government Accountability Office (GAO) draft report entitled VA POLICE: Actions Needed To Improve Data Completeness And Accuracy On Use Of Force Incidents At Medical Centers (GAO-20-599).

The enclosure contains general comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on the draft report.

Sincerely,

Brooks D. Tucker

Acting Chief of Staff

Enclosure

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Department of Veterans Affairs' (VA) Response to Government Accountability Office (GAO) Draft Report

VA POLICE: Actions Needed to Improve Data Completeness and Accuracy on Use of Force Incidents at Medical Centers

(GAO-20-599)

Recommendation 1: The Secretary of the VA should improve the completeness and accuracy of use of force data in Report Executive by addressing (1) incompleteness categorization of the type of force used, (2) inaccurate data on the highest level of force used, and (3) the potential for duplicate data entries.

VA Response: Concur.

1. Incomplete categorization of the type of force used – Database is being modified to prompt officers to complete use of force (UoF) entries with the appropriate categories and subcategories. Logic checks will be incorporated into the software that prompt the officer to complete the type of force used before being allowed to move on to the next section.

2. Inaccurate data on the highest level of force used – UoF drop down options were re-evaluated and revised based on the feedback from GAO. The revision was completed using the current VA Police UoF policy and listed in ascending order from lowest level of force used to the highest level of force used. The options were revised to help alleviate officer error when selecting the correct UoF option used. Revising the use of force options will allow the officer completing the incident report involving UoF a more accurate choice of the action taken. This will increase the integrity and trust of the data being pulled regarding UoF incidents.

3. The potential for duplicate data entries – The potential for duplicate entries can be reduced by ensuring the proper steps are being followed during the report review process at the station level. Each station currently has incident report review levels in place allowing first line supervisors and second level police management to review and ensure accuracy of an officer's report

entries before the report is approved and archived. The incident numbers are generated automatically for each station. Once a number is assigned, that number cannot be issued for a different report. Follow-up reports can be generated but the follow-up report number is appended with a sequential number to alleviate duplicate reports as well.

In order to improve the quality of data, more emphasis will be placed on Report Executive training and comprehensive reviews conducted by facility level police leadership. This will be validated during the program inspections.

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Recommendation 2: The Secretary of the VA should implement plans to include analytical features in Report Executive that will position the agency to analyze use of force data at VA medical centers nationwide, including by officer, type of force used, and facility, among other variables.

VA Response: Concur. Report Executive currently possesses the analytical features and analytical tools that allow entered UoF data, as well as other incident data, to be analyzed by officer, type of force used, facility and other variables. The features also allow the data to be analyzed for comparisons using date ranges, days of the week and also allows for comparison of the same timeframe from one year to the next for resource planning. Additional program capabilities are being developed by the vendor to allow for future system growth, such as adding a “tab” to sort and collect data by region/Veterans Integrated System Network.

Recommendation 3: The Secretary of the VA should ensure medical centers submit records of all locally initiated used of force investigations and any resulting disciplinary action to VA headquarters office(s) with responsibility for police oversight.

VA Response: Concur. The Office of Human Resources and Administration/Office of Operations, Security and Preparedness (HRA/OSP) Office of Security and Law Enforcement will work with the Veterans Health Administration (VHA) to establish a process to ensure the results of disciplinary action taken against VA Police Officers, pertaining to UoF matters, are forwarded to VA headquarters office(s) with responsibility for police oversight.

Recommendation 4: The Secretary of the VA should implement plans for obtaining a quality database to collect all locally initiated use of force investigation at medical centers.

VA Response: Concur. HRA/OSP's Office of Security and Law Enforcement will work with VHA to identify and obtain a suitable database capable of tracking and analyzing investigative data.

Recommendation 5: Once positioned to do so, the Secretary of the VA should analyze all use of force investigations and any resulting disciplinary action by facility, officer, and outcome, among other variables.

VA Response: Concur. Once a suitable database is obtained, either by programming improvements to Report Executive or by obtaining a new product, it will be used to track UoF incidents. HRA/OSP's Office of Security and Law Enforcement will analyze the data and provide appropriate reports to senior VA leadership.

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General Comments:

VHA intends to collaborate with VA's Office of Security and Preparedness to establish processes to monitor UoF incidents using data based solutions. Policy will be implemented to ensure there is accountability for UoF incidents that violate rules or procedures guiding VA police officer authority to use force.

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