DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON, DC 20420

March 12, 2026

The Honorable Jerry Moran
Chairman
Committee on Veterans' Affairs
U.S. Senate
Washington, DC 20510

The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
U.S. Senate
Washington, DC 20510

Dear Chairman Moran and Ranking Member Blumenthal,

I am writing to update your office regarding an inquiry made by your staff concerning allegations they received from a confidential complainant that then leaders from the VA Northern Indiana Healthcare System (the healthcare system), who are no longer leaders at that healthcare system, mishandled an employee's harassment complaint and subsequent investigation following the employee's death by suicide. The allegations further state that in late 2023, the employee (who was also a veteran) made a report to the healthcare system's Equal Employment Opportunity (EEO) manager alleging harassment in the workplace.

After a preliminary review of the allegation, the Office of Inspector General (OIG) opened an administrative investigation in May 2024 to examine the circumstances surrounding the employee's death and to determine whether healthcare system leaders took appropriate action to address the harassment complaint. The OIG investigative team interviewed 25 VA employees, including the healthcare system's EEO manager and the then acting leaders at the healthcare system. The team also reviewed thousands of documents, including emails, correspondence, and records related to the investigation into the employee's harassment complaint.[1]

Following this investigation, the OIG did not substantiate the confidential complainant's allegations. First, the complainant alleged that the employee had reported harassment to the EEO manager weeks before dying. However, the OIG found that the employee contacted the EEO manager two days prior and did not file a formal complaint. Healthcare system leaders learned of the alleged harassment at that time. Second, the complainant suggested that healthcare system leaders assigned the manager of the employee's work unit, where the alleged harassment

[1] The OIG conducted this administrative investigation from May 2024 to January 2025, with additional follow-up work in September 2025.

occurred, to oversee the investigation into the employee's complaint. The OIG determined that this manager did not direct or manage the internal investigation. Third, the complainant asserted that healthcare system leaders failed to convene a formal Administrative Investigation Board (AIB) following the employee's death, but the OIG did not find a violation of applicable VA policy because discretion is allowed in selecting the type of administrative investigation to pursue in these circumstances.[2] Moreover, had the employee filed a formal EEO complaint, the appropriate inquiry would have been an EEO investigation, not an AIB.[3] Fourth, the OIG investigators noted that the employee's VA health record contained no evidence of receiving mental health peer support services while working at the healthcare system, contrary to the complainant's allegations. The employee was on administrative leave and off VA property at the time of death. The employee had last received mental health care from VA in 2019. However, the employee was enrolled in VA's healthcare system.

Finally, the complainant alleged that the employee had been seen in an emergency department the week of the employee's death. Although the OIG found that the employee briefly visited an emergency department at the healthcare system on the day of their death, staff had limited interactions. On that day, the employee presented to an emergency department nurse, denied having suicidal ideation when she asked, and then left within four minutes.

The OIG acknowledges the seriousness of these allegations and completed a full administrative investigation. However, based on the evidence, investigators found the allegations were unsubstantiated. The OIG closed the matter and no further action will be taken at this time.

Sincerely,

CHERYL L. MASON

Copy to: Under Secretary for Health, Department of Veterans Affairs
The Honorable Susan Collins, Chairwoman, Committee on Appropriations, U.S. Senate
The Honorable Patty Murray, Vice Chair, Committee on Appropriations, U.S. Senate
The Honorable Rand Paul, Chairman, Committee on Homeland Security & Governmental Affairs, U.S. Senate
The Honorable Gary Peters, Ranking Member, Committee on Homeland Security & Governmental Affairs, U.S. Senate

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[2] Under VA policy, an official generally has discretion to select an appropriate form of administrative investigation, either a less formal fact-finding investigation or a more formal administrative investigation board. VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021, pp. 6, 18, 19.

[3] VA Handbook 5977, *Equal Employment Opportunity Discrimination Complaints Process*, February 7, 2007, pp. 23–24.

The Honorable Tom Cole, Chairman, Committee on Appropriations, U.S. House of Representatives
The Honorable Rosa DeLauro, Ranking Member, Committee on Appropriations, U.S. House of Representatives
The Honorable James Comer, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives
The Honorable Robert Garcia, Ranking Member, Committee on Oversight and Government Reform, U.S. House of Representatives
The Honorable Mike Bost, Chairman, Committee on Veterans' Affairs, U.S. House of Representatives
The Honorable Mark Takano, Ranking Member, Committee on Veterans' Affairs, U.S. House of Representatives