



Department of Veterans Affairs

Office of Inspector General

April 2013 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Testifies on Challenges Facing VA

Richard J. Griffin, Deputy Inspector General, testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States Senate, on the recent results and recommendations of Office of Inspector General (OIG) reports on VA programs and operations in connection with VA's fiscal year (FY) 2014 budget request. Specifically, he focused on OIG work in the area of claims processing and access to health care. Mr. Griffin was accompanied by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations (AIGAE), and Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections. [\[Click here to access testimony.\]](#)

AIGAE Discusses OIG's Recommendations to National Cemetery Administration To Improve Gravesite Reviews

Linda A. Halliday, AIGAE, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on the results of the OIG's audit of the National Cemetery Administration's (NCA) internal gravesite reviews. She discussed OIG's findings that NCA's Phase One review did not identify or report all misplaced headstones and unmarked gravesites. The audit also reported that NCA's review lacked controls to ensure an independent review was conducted; NCA did not allow adequate time or resources to conduct the review; and cemetery directors lacked updated gravesite layout maps. Ms. Halliday also commended the Under Secretary for Memorial Affairs for acting immediately when presented with the OIG's findings. Ms. Halliday was accompanied by Ms. Cherie Palmer, Director of the OIG's Chicago Office of Audits and Evaluations. [\[Click here to access testimony.\]](#)

OIG REPORTS

Review Finds Mismanagement, Lack of Oversight, and Coordination of Contracted Mental Health Care at Atlanta VA Medical Center

OIG conducted an inspection to assess the merit of allegations of mismanagement and lack of oversight of a mental health (MH) contract. OIG substantiated mismanagement in the administration of the contract, and also substantiated additional allegations that there was inadequate coordination, monitoring, and staffing for oversight of contracted MH patient care. Facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the contracted MH program. MH Service Line managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety. The lack of effective patient care management and program oversight by the facility contributed to problems with access to MH care and contributed to "patients falling through the cracks." OIG recommended that the Under Secretary for Health (USH) rectify the deficiencies described in this report with respect to the provision of

quality MH care and contract management, with the goal that Veterans receive the highest quality medical care from either the VA or its partners. The USH and the Veterans Integrated Service Network (VISN) and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the planned actions until they are completed. [\[Click here to access report.\]](#)

IG Finds Need for National Policies on Contraband, Visitors, Drug Screening, and Escorts in Inpatient MH Units

OIG evaluated allegations regarding the MH Service Inpatient Unit at the Atlanta VA Medical Center (VAMC), Decatur, GA. Specifically, the complainant alleged that an inpatient's death was due to MH service leadership's negligence and mismanagement of unit policies, patient monitoring, staffing, and lack of caring about patients. OIG did not substantiate the allegations of inadequate staffing, inappropriate staff assignments, or that leadership did not care about patients. However, OIG substantiated that the VAMC did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. OIG found inadequate program oversight including a lack of timely follow-up actions by leadership in response to patient incidents. OIG recommended that the USH ensure that Veterans Health Administration (VHA) develops national policies to address contraband, visitation, urine drug screening, and escort services for inpatient MH units. OIG also recommended that the VISN and Facility Directors ensure that the inpatient MH unit develops these policies; strengthen program oversight and follow-up; improve communication with staff; and ensure functional and well-maintained life support equipment. [\[Click here to access report.\]](#)

IG Makes Five Recommendations To Mitigate Legionnaires' Disease at VA Pittsburgh Healthcare System

OIG conducted a review of Legionnaires' disease (LD) at the VA Pittsburgh Healthcare System (VAPHS). VAPHS has a long history of comprehensive mitigation efforts for LD, and following a recent outbreak, VAPHS instituted numerous additional measures. However, OIG found that VAPHS inadequately managed its water treatment systems during 2011–2012. OIG also found that VAPHS did not conduct routine flushing of hot water faucets and showers as recommended by the manufacturer of the water treatment systems. OIG found that VAPHS conducted environmental surveillance in accordance with VHA guidance. However, VAPHS responded to positive cultures with corrective actions inconsistent with VHA or Centers for Disease Control and Prevention guidance. In addition, VAPHS did not test all health care-associated pneumonia patients for Legionella as required by VHA for transplant centers with a history of health care-associated LD. OIG recommended that the VAPHS Director ensure that any disinfectant system in use for Legionella prevention is monitored and maintained in accordance with manufacturer's instructions, that hot-water faucets and showerheads are routinely flushed, and that close coordination between the Infection Prevention Team and Facilities Management Service staff occurs. Additionally, OIG recommended that the VAPHS Director ensure that when environmental cultures are positive, actions taken comply with VHA guidelines, and that all health care-associated pneumonia patients are tested for Legionella infection. [\[Click here to access report.\]](#)

Review Shows Use of Camera for Patient Safety Concerns Reasonable at Tampa VAMC

At the request of several members of Congress, OIG initiated a review that a hidden camera was placed in a brain-damaged patient's room without next-of-kin consent. In June 2012, the patient's family became aware of a video surveillance camera (VSC) in a smoke-detector-like cover that had been placed in the patient's room. The patient's family was aware when the VSC was activated 3 days after installation. OIG concluded that the use of the camera for patient safety concerns was reasonable. OIG conducted a survey of VSC usage in VHA health care facilities. VHA requires VSCs in MH Residential Rehabilitation Treatment Program facilities, pharmacy vaults and controlled substances storage areas, childcare facilities, and canteens. VSCs are standard in high traffic areas such as parking lots, building entrances, waiting rooms, stairwells, and research areas. VSCs were reported in clinical areas such as: MH Units, Emergency Departments, Intensive Care Units, and Geriatrics/Extended Care Units. Half of the respondents had posted signs that VSCs were in use. No facility reported current use of a hidden camera. Seven facilities employed hidden VSCs in the past for law enforcement and/or suspected criminal activity. Ten medical centers reported current use of VSCs with audio capability in police interview rooms; sleep laboratories; MH seclusion rooms; and in the common area of the VA Manila, PI, Outpatient Clinic located on U.S. Embassy property. OIG recommended that the USH ensure that VHA policy addresses the clinical uses of covert and overt VSCs in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, health care operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered. The USH concurred with OIG's recommendation and provided an acceptable action plan. [\[Click here to access report.\]](#)

Changes Needed in Approval Methods for Veterans Retraining Assistance Program To Reach 99,000 Participants

During OIG's ongoing national audit of the Veterans Retraining Assistance Program (VRAP), OIG determined that if the Veterans Benefits Administration (VBA) continued to use the current method of counting authorized participants, Veterans' use of VRAP would not achieve the levels authorized by Congress. The *Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011* authorized benefits for 99,000 participants from October 1, 2011, through March 31, 2014. In order not to exceed the authorized limit of participants, officials counted approved applicants as participants. However, not all approved applicants were actually participating in the program. As of February 2013, about 33 percent of the authorized participants were enrolled and receiving program benefits. OIG recommended VBA continue to accept applications until they have 99,000 Veterans enrolled in an approved training program or until October 1, 2013, the last date a Veteran may apply for program benefits. The Under Secretary for Benefits concurred with OIG's recommendations. [\[Click here to access report.\]](#)

Combined Assessment Program Review Summary Report Recommends Three Ways To Improve Quality Management at VAMCs

OIG completed an evaluation of quality management (QM) in VHA facilities for FY 2012. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. OIG conducted this review at 54 facilities during Combined Assessment Program (CAP) reviews performed from October 1, 2011, through September 30, 2012, and identified three areas where VHA facilities needed to improve compliance. OIG recommended that Facility Directors and Patient Safety Officers sit on the high-level committees that review QM results, that completed corrective actions related to peer review be reported to the Peer Review Committee, and that Focused Professional Practice Evaluations for newly hired licensed independent practitioners be initiated and completed and that the results be reported to the Medical Executive Committee. [\[Click here to access report.\]](#)

CAP Review Summary Report Recommends Improvements in Post-Discharge Follow Up for MH Patients

OIG completed an evaluation of continuity of care for MH patients at VHA facilities. The purpose of the evaluation was to determine whether patients who were discharged from acute MH units received timely follow-up. OIG conducted this review at 24 facilities during CAP reviews performed from April 1 through September 30, 2012, and identified two areas where VHA facilities needed to improve compliance. OIG recommended that facilities take action to improve post-discharge follow-up for MH patients, particularly those who were identified as high risk for suicide and that clinicians consistently follow up with patients who do not report to their scheduled MH appointments and that all of these contacts be documented. [\[Click here to access report.\]](#)

CAP Review Summary Report Recommends VHA Fully Implement Nurse Staffing Methodology

OIG completed an evaluation of nurse staffing in VHA facilities. The purpose of the evaluation was to determine the extent to which VHA facilities implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit. OIG conducted this review at 27 facilities during CAP reviews performed from April 1 through September 30, 2012, and identified two areas where VHA facilities needed to improve compliance. OIG recommended that all facilities fully implement the staffing methodology and complete all required steps, and improve processes to use the available data to manage and provide safe, cost-effective staffing.

[\[Click here to access report.\]](#)

Benefits Inspection Results for Philadelphia, Pennsylvania, VA Regional Office

OIG conducted this inspection to evaluate how well the Philadelphia, PA, VA Regional Office (VARO) accomplishes its mission. OIG found VARO staff did not accurately process 22 (37 percent) of 60 disability claims reviewed. Specifically, 50 percent of the 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate because of lack of management oversight to ensure staff took timely actions to reduce Veterans'

benefits as appropriate. Further, staff did not follow VBA or local policy for scheduling future medical reexaminations. VARO staff inaccurately processed 7 of 30 traumatic brain injury (TBI) claims because they did not always comply with second signature requirements and used insufficient medical examination reports to evaluate these claims. VARO managers generally ensured staff completed Systematic Analysis of Operations (SAO) as required. However, staff did not always advise Gulf War Veterans they were entitled to MH treatment at VA facilities. Managers also did not ensure staff updated the homeless Veterans outreach directory, nor did staff contact all homeless facilities in their jurisdiction. OIG recommends the VARO Director develop and implement plans to ensure timely benefits reduction actions, provide refresher training on scheduling future medical reexaminations, and ensure staff follow second signature requirements and return insufficient medical examination reports for TBI claims. Also, controls are needed to ensure staff update the resource directory and contact all homeless facilities in their jurisdiction. The VARO Director concurred with OIG's recommendations. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Benefits Inspection Results for Baltimore, Maryland, VARO

OIG evaluated the Baltimore, MD, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 28 (68 percent) of the 41 disability claims reviewed. Specifically, 83 percent of the 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, primarily because of a lack of management oversight to ensure staff took timely actions to schedule future medical reexaminations when alerted to do so. VARO staff inaccurately processed 3 of 11 TBI claims when they did not follow VBA's policy for second signature reviews. Also, VARO staff did not always timely complete SAOs or address Gulf War Veterans' entitlement to MH treatment. Further, VARO staff did not conduct homeless Veterans outreach activities as required. OIG recommended the VARO Director implement a plan to ensure scheduling of medical examinations to support temporary 100 percent disability reevaluations. Further, management should ensure staff follows VBA's second signature review requirements for TBI claims. The Director needs to implement plans to ensure managers timely complete SAOs and accomplish all required homeless Veterans outreach activities. The VARO Director concurred with OIG's recommendations. [\[Click here to access report.\]](#)

Benefits Inspection Results for Denver, Colorado, VARO

OIG evaluated the Denver, CO, VARO to see how well it accomplishes its mission. VARO staff did not accurately process 20 (33 percent) of 60 disability claims OIG reviewed. Specifically, 16 of the 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate. Generally, errors in processing the temporary evaluations occurred because staff did not establish controls to ensure scheduling of future medical reexaminations to reevaluate these cases. This occurred due to incorrect guidance and ineffective training. In addition, VARO staff inaccurately processed 4 of 30 TBI claims. VARO managers generally ensured staff completed SAOs and addressed Gulf War Veterans' entitlement to MH treatment as required. Denver VARO staff provided

adequate, but limited, outreach to homeless Veterans. The VARO Director concurred with OIG's recommendation. [\[Click here to access report.\]](#)

Benefits Inspection Results for Boise, Idaho, VARO

OIG evaluated the Boise, ID, VARO to see how well it accomplishes its mission. VARO staff did not accurately process 16 (46 percent) of 35 disability claims OIG reviewed. Specifically, 14 of the 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, generally, because VARO staff did not establish controls to request future medical reexaminations. VARO performance was generally effective in processing TBI claims. Managers did not ensure staff completed SAOs or addressed Gulf War Veterans' entitlement to MH treatment. Boise VARO staff provided adequate outreach to homeless Veterans; however, VBA needs a measure to assess its outreach program. The VARO Director concurred with OIG's recommendations.

[\[Click here to access report.\]](#)

Inspection Results for Clinics in Multiple VAMCs

OIG reviewed the Battle Creek VAMC's four Community Based Outpatient Clinics (CBOCs) during the week of December 3, 2012, and the Captain James A. Lovell Federal Health Care Center's three CBOCs during the week of December 10, 2012. The purpose of the review was to assess whether the CBOCs provide Veterans with consistent and safe high-quality health care. The review covered the clinical care components of women's health cervical cancer screening and tetanus and pneumococcal vaccinations. OIG also randomly selected the Grand Rapids and Lansing, MI, CBOCs and the Evanston and McHenry, IL, CBOCs for site visits and evaluated credentialing and privileging, environment of care, and emergency management processes. OIG noted opportunities for improvement and made a total of 15 recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Central Arkansas Veterans Healthcare System's eight CBOCs and the G.V. (Sonny) Montgomery VAMC's seven CBOCs during the week of March 4, 2013. OIG noted opportunities for improvement and made a total of seven recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Robley Rex VAMC's eight CBOCs during the week of February 25, 2013. OIG noted opportunities for improvement and made a total of seven recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Dayton VAMC's four CBOCs during the week of January 28, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

Former Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 41 months' incarceration, 36 months' supervised probation, and ordered to pay \$639,618 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant

embezzled \$460,679 of VA benefits and \$176,246 of Social Security benefits from an incompetent Veteran. The defendant admitted to submitting fraudulent accountings to both VA and the court by altering reports and creating fraudulent certificates of deposit.

Construction Company Owner Charged in Service-Disabled Veteran-Owned Small Business Fraud

The owner of a large construction company was charged with obstructing a grand jury investigation by altering and deleting documents from his computer. A VA OIG, General Services Administration OIG, Army Criminal Investigation Command, Small Business Administration (SBA) OIG, and Department of Labor OIG investigation revealed that the defendant, a minority owner of two Service-Disabled Veteran-Owned Small Businesses, received a grand jury subpoena for records relating to his business dealings with another company. The defendant deleted documents on his computer that were required by the subpoena.

Business Owner Pleads Guilty to Making False Statements

A business owner pled guilty to making false statements. A VA OIG and SBA OIG investigation revealed that the defendant used personal information from a service-disabled Veteran to form a joint venture. The defendant then signed the Veteran's name on bids and correspondence and was subsequently awarded two VA construction contracts for \$1,029,598.

Defendant Sentenced for Theft of Veterans' Identities

A defendant was sentenced to 65 months' incarceration, 36 months' supervised probation, ordered to pay \$462,039 in restitution, and forfeit \$159,265 after pleading guilty to wire fraud and aggravated identity theft. An OIG, Internal Revenue Service Criminal Investigation Division, and local police investigation revealed that the defendant used Veterans' personal identifying information stolen from VA medical records to file fraudulent Federal income tax returns. Additional stolen identities of non-Veterans obtained outside VA were also used by the defendant during this scheme. The defendant received approximately \$462,039.60 in illicit proceeds from fraudulent returns and attempted to file additional fraudulent income tax returns in an amount exceeding \$600,000.

Veteran Charged with Assault of Portland, Oregon, VAMC Nurse

A Veteran was charged with assault of a Federal employee. An OIG and VA Police Service investigation revealed that the Veteran, who was an inpatient at the Portland, OR, VAMC, assaulted a registered nurse. The defendant punched the nurse in the face and broke his jaw.

Veteran Arrested for Assault of Northport, New York, VAMC Employee

A Veteran was arrested for the assault of a Northport, NY, VAMC employee and patient. An OIG and VA Police Service investigation revealed that the defendant, while an inpatient, assaulted a VA pharmacy technician and a fellow patient, resulting in extensive head injuries to the employee. The defendant previously assaulted a VAMC nurse and VA police officer in the emergency room. The defendant was criminally

charged based on the severity of the injuries sustained by the victims and the subject's past history of violence. The defendant is being held without bail pending a psychiatric evaluation.

Former Atlanta, Georgia, VAMC Compensated Work Therapy Employee Indicted for Making Terroristic Threats

A former Atlanta, GA, VAMC Compensated Work Therapy Program employee was indicted for making terroristic threats. An OIG and VA Police Service investigation revealed that the defendant threatened to assault his supervisor after he accused the supervisor of intentionally short-changing his salary. During the course of the investigation, the defendant also threatened to shoot law enforcement officers if they attempted to initiate contact with him.

Veteran Sentenced for Making Threat to Montgomery, Alabama, VARO Employee

A Veteran was sentenced to 90 days' incarceration, \$392 in court costs, and ordered to attend anger management counseling after being found guilty of the harassment of a VA employee. Seventy-six days of the incarceration were suspended contingent upon successful completion of the course. Also, the defendant was ordered to avoid contact with the VA employee and to not visit the Montgomery, AL, VARO. The OIG investigation determined that the defendant threatened to shoot a VA vocational rehabilitation employee.

Veteran Sentenced for Making Threat to Memphis, Tennessee, VAMC Physician

A Veteran was sentenced to time served, 1 year of probation, and ordered not to visit the Memphis, TN, VAMC for 3 years after pleading guilty to knowingly and recklessly causing fear of imminent bodily injury to another. The defendant was involuntarily committed for a mental evaluation after his arrest. An OIG investigation revealed that the defendant harassed and threatened a VA physician after he refused to prescribe pain medication to the defendant.

Veteran Sentenced for Making Threats to Dothan, Alabama, CBOC

A Veteran was sentenced to 10 years' incarceration (suspended), 3 years' probation, a \$1,500 fine, and ordered to have no contact with the VA clinic in Dothan, AL, after pleading guilty to making terroristic threats. An OIG investigation revealed that the defendant threatened to use his .45 caliber handgun to kill 42 people at the Dothan, AL, CBOC. The initial contact with the defendant at his residence resulted in a 2-hour standoff as he barricaded himself in his home with a firearm. The defendant was arrested without incident after he attempted to flee from the residence.

Two Seattle, Washington, VAMC Travel Clerks Plead Guilty in Travel Benefit Fraud Investigation

Two Seattle, WA, VAMC travel clerks pled to conspiracy to defraud the United States and solicitation and receipt of bribes by a public official. The defendants, along with nine Veterans, participated in a conspiracy to defraud VA by submitting hundreds of inflated and fictitious travel benefit vouchers to the VAMC. Kickbacks were paid by the

Veterans to the travel clerks who processed the vouchers. The estimated loss is in excess of \$160,000.

Former Jamestown, New York, CBOC Nurse Indicted for Drug Violations

A former registered nurse at Jamestown, NY, VA CBOC was indicted and arrested for conspiracy, possession with intent to distribute a controlled substance, and obtaining a controlled substance by fraud. An OIG and local police investigation determined that the defendant stole prescription forms from a nurse practitioner at the clinic and subsequently forged prescriptions for Oxycontin that she then sold to co-conspirators for cash. A friend of the defendant was also arrested and charged with possession of a controlled substance and possession of a forged instrument. The friend received multiple forged Oxycontin prescriptions in his name from the defendant and filled them at local pharmacies.

Former Nashville, Tennessee, VAMC Nursing Assistant Sentenced for Elder Abuse

A former Nashville, TN, VAMC certified nursing assistant was sentenced to 12 months' incarceration (suspended), 12 months' supervised probation, and a \$444 fine after pleading guilty to abuse or neglect of an impaired adult. The sentencing prohibits the defendant from working as a nursing assistant during the probationary period. An OIG investigation revealed that the defendant removed fentanyl patches from terminally ill patients and either placed them on his own body or chewed them to support his drug addiction. The employee resigned from his position at the VAMC after conviction.

Manchester, New Hampshire, VAMC Physician Sentenced for Fraudulently Obtaining Controlled Substances

A Manchester, NH, VAMC physician was sentenced to 3 years' probation as a result of his conviction for fraudulently obtaining controlled substances. A VA OIG, Drug Enforcement Administration (DEA), and Office of Personnel Management OIG investigation disclosed that from June 2010 to January 2011, the defendant wrote approximately 17 prescriptions (68,760 total milligrams) for oxycodone and Oxycontin that were not documented in the medical records of one of his patients. Some of these prescriptions were written for the patient after the defendant went on workers' compensation leave. This was in addition to 82,800 mg of oxycodone and Oxycontin that the patient received from VA during the same time period. The patient later provided some of these pills to the defendant. As part of his plea agreement, the defendant agreed to surrender his DEA registration and to never seek another one. The defendant also entered into a separate civil agreement to resolve allegations that he violated Federal regulations when he issued prescriptions that were not for a legitimate medical purpose and were outside the scope of his DEA registration. While not admitting to any wrongdoing, the defendant paid \$25,000 to resolve his potential civil liability.

Former VA Homeless Grant and Per Diem Program Participant Pleads Guilty to Making False Statements

A former participant in the VA Homeless Grant and Per Diem program pled guilty to making false statements to VA. An OIG investigation revealed that the defendant made false representations when applying for a grant to provide funds for the purchase of property to be used to house indigent Veterans. The defendant later admitted to keeping \$25,000 of the \$80,600 provided by VA and failing to make mortgage payments, which resulted in foreclosure. The defendant also received an additional \$280,000 in grant funds for the purchase of an apartment building to house Veterans and a specialty van to provide transportation for indigent Veterans, neither of which was purchased.

Veteran Pleads Guilty to Theft of Government Funds

A Gulf War Veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant submitted false claims to VA, related to post-traumatic stress disorder, in order to receive health care and compensation benefits that she was not entitled to receive. The defendant, who claimed to be unemployable and housebound since 1996, earned a Bachelor's and Master's Degree in Education and worked full-time as a teacher. The loss to VA is \$205,402.

Defendant Sentenced after Pleading Guilty to Fraud

A defendant was sentenced to 30 months' incarceration, 36 months' supervised release, and ordered to pay VA \$437,000 in restitution after pleading guilty to wire fraud. An OIG and Naval Criminal Investigative Service investigation revealed that the defendant submitted fraudulent science and engineering degrees to the U.S. Navy and was subsequently accepted into the nuclear program with the rank of Ensign. The defendant then used her fraudulently acquired military status to apply for a VA-backed home loan and submitted forged and fraudulent bank statements and military documents confirming her actual and anticipated income and assets. In 2010, after the investigation revealed that the defendant had never been awarded any of the degrees, she was court-martialed and incarcerated for the false representations relating to her enlistment. The defendant will serve her new sentence after her current period of imprisonment.

Veteran Sentenced for VA Education and Health Care Fraud

A Veteran was sentenced to 12 months' incarceration, 3 years' supervised probation, and ordered to pay VA \$10,051 in restitution. An OIG investigation determined that the defendant submitted fraudulent DD-214s to the Montana National Guard and the Ft. Harrison, MT, VAMC. Before being discharged from active duty as "Other than Honorable," the Veteran purchased eight fictitious DD-214s from a service member at the Miramar Air Force Base indicating an "Honorable" discharge. The Veteran then used an ink signature stamp to make the DD-214s appear more authentic. The Veteran submitted one of the fictitious DD-214s to re-enter the military, where he immediately made a claim for VA educational benefits under the GI Bill. The Veteran also submitted one of the fictitious DD-214s to the VAMC and began receiving VA health care benefits to which he was not entitled.

Veteran Sentenced to Prison for Travel Benefit Fraud

A Veteran was sentenced to 4 months' incarceration, 2 years' probation, and ordered to pay VA \$9,173 in restitution after pleading guilty to fraudulent schemes. An OIG investigation revealed that the defendant submitted false travel claims to the Prescott, AZ, VAMC claiming that she was traveling over 500 miles roundtrip, when in actuality she was traveling only 180 miles.

Veteran Indicted for Travel Benefit Fraud

A Veteran was indicted for theft of Government funds. An OIG investigation revealed that the defendant submitted false travel claims to the Tucson, AZ, VAMC certifying that he was traveling approximately 500 miles roundtrip, when in actuality he was riding his bicycle a few blocks to the VAMC. The loss to VA is approximately \$30,500.

Veteran Sentenced for Travel Benefit Fraud

A Veteran, who previously pled guilty to filing false claims for travel benefits, was sentenced to 5 years' probation and ordered to pay VA \$17,361 in restitution. An OIG investigation disclosed that from June 2009 to February 2012 the defendant submitted 156 false travel claims reporting that he was driving to the Togus, ME, VAMC from locations that were over 300 miles roundtrip, when in actuality he resided only 3 miles from the VAMC.

A Non-Veteran Pleads Guilty to Theft of VA Health Care Benefits

A non-Veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant never served in the U.S. Marine Corps or sustained the injuries supposedly caused by an improvised explosive device while serving in Afghanistan. As a result, the defendant fraudulently obtained approximately \$100,000 of VA medical benefits he was not entitled to receive.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 15 months' incarceration, 3 years' supervised release, and ordered to pay restitution of \$77,850 after pleading guilty to theft of Government funds. An OIG investigation revealed that for over 4 years the defendant was receiving individual unemployment benefits while employed with the U.S. Coast Guard.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased VA beneficiary was sentenced to 4 years' probation and ordered to pay \$63,300 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA benefits that were direct deposited into a joint account after her mother's death in May of 2007. The defendant admitted to converting the funds for personal use.

Son of Deceased Veteran Sentenced for Theft of VA Funds

The son of a deceased Veteran was sentenced to 366 days' incarceration, 3 years' supervised release, and ordered to pay \$202,662 in restitution. An OIG investigation determined that the defendant stole VA benefits that were direct deposited into a joint

account after his father's death in March 2006. The defendant admitted to spending the stolen funds at nightclubs and playing golf.

VA Beneficiary Pleads Guilty to Theft of Government Funds and False Statements

A VA beneficiary pled guilty to theft of Government funds and false statements. An OIG investigation revealed that the beneficiary failed to notify VA that she remarried in 1978 and subsequently submitted numerous fraudulent VA marital status questionnaires. The defendant fraudulently received VA benefits from 1978 to 2011. The loss to VA is \$308,040.



*(original signed by Richard J. Griffin,
Deputy Inspector General for:)*

GEORGE J. OPFER
Inspector General