



# Department of Veterans Affairs Office of Inspector General

---

## **Administrative Investigation Failure to Properly Report a Felony to OIG, Interference with an OIG Investigation, and Lack of Candor Lebanon VA Medical Center, PA**

**WARNING**  
**5 U.S.C. §552a, PRIVACY ACT STATEMENT**

**This final report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. §552a). Such information may be disclosed only as authorized by this statute. Questions concerning release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.**



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington, DC 20420**

**TO:** Assistant Secretary for Operations, Security, and Preparedness  
Deputy Under Secretary for Health for Operations and Management

**SUBJECT:** Administrative Investigation, Failure to Properly Report a Felony to  
OIG, Interference with an OIG Investigation, and Lack of Candor,  
Lebanon VA Medical Center, PA (2011-03720-IQ-0196)

## **Summary**

We substantiated that Mr. Robert W. Callahan, Jr., Medical Center Director, Lebanon VA Medical Center, Pennsylvania, failed to ensure that information about a possible criminal matter involving a felony was promptly referred to the Office of Inspector General (OIG), Office of Investigations. In addition, Mr. Callahan interfered with an OIG investigation when he asked a subordinate to provide him key information about events that he reasonably knew OIG would ask him about during his interview, and he did not testify freely and honestly in connection with our investigation.

## **Introduction**

The VA OIG Administrative Investigations Division investigated an allegation that Mr. Callahan directed his staff to delay notifying OIG about suspected drug diversion activity occurring at the medical center. To assess this allegation, we interviewed Mr. Callahan and other medical center staff, and reviewed VA Police Uniformed Offense Reports (UOR), email records, and applicable Federal laws, regulations, and VA policy.

### *Background*

On April 10, 2003, VA published a final rule in the *Federal Register* pertaining to the Referral of Information Regarding Criminal Violations. 68 Fed. Reg. 17549, (April 10, 2003). The final rule required VA employees to report information about possible criminal activity to appropriate authorities; VA Management Officials to report criminal violations occurring on VA property to VA Police; and VA Management Officials with information of possible criminal activity involving felonies to ensure and be responsible for prompt referral to OIG.

In a June 2011 United States Government Accountability Office (GAO) report to the Committee on Veterans' Affairs, House of Representatives, titled *VA Health Care, Actions Needed to Prevent Sexual Assaults and Other Safety Incidents*, GAO reported:

GAO found that many of the nearly 300 sexual assault incidents reported to the VA police were not reported to VA leadership officials and the VA OIG. Specifically, for the four VISNs GAO spoke with, VISN and VA Central Office officials did not receive reports of most sexual assault incidents reported to the VA police. Also, nearly two-thirds of sexual assault incidents involving rape allegations originating in VA facilities were not reported to the VA OIG, as required by VA regulation. In addition, GAO identified several factors that may contribute to the underreporting of sexual assault incidents including unclear guidance and deficiencies in VA's oversight.

## Results

### Issue 1: Whether Mr. Callahan Failed to Report Felony Criminal Activity to OIG

Federal regulations require that criminal matters involving felonies should be **immediately referred to the OIG Office of Investigations**. In addition, regulations state that VA Management Officials with information about **possible criminal matters involving felonies** will ensure and be responsible for prompt referrals to OIG. (Emphasis added.) For examples of crimes constituting felonies, the regulations cite: theft of Government property over \$1,000; false claims; false statements; drug offenses; crimes involving information technology systems; and serious crimes against persons, i.e., homicide, armed robbery, rape, aggravated assault, and serious physical abuse of a VA patient. 38 CFR § 1.204. VA Policy for Security and Law Enforcement (SLE) requires that each facility publish a standard operating procedure (SOP) for Police and Security Operations that is consistent with VA's SLE policy and Federal laws and regulations. VA Handbook 0730, Paragraph 5(a)(1), (August 11, 2000).

On the evening of June 29, 2011, the VA Integrated Operations Center (IOC) sent an email containing a Veterans Health Administration (VHA) Issue Brief (IB) to OIG reporting that earlier that morning an employee of the Lebanon VA Medical Center, a Licensed Practical Nurse, hereinafter referred to as "the Nurse," was arrested by VA Police on charges involving the alleged diversion of morphine and oxycodone (narcotic pain relievers). The IB reported that 8 days earlier Mr. Callahan and Ms. [REDACTED] Associate Director for Patient Care Services, requested an investigation into "the on-duty activities" of the Nurse, after they learned that the Nurse may be diverting drugs. The Nurse's coworker reported an unusual frequency of PRN (*pro re nata* or when necessary) medication administered by the Nurse to a particular patient and that the patient never required those medications when other clinicians were on duty. The IB

(b)(7)(c)

described various VA police and management investigative activities that ensued over the next 8 days that culminated in the arrest of the Nurse.

After receiving the VHA IB, OIG officials found that neither medical center management nor police notified OIG of the suspected drug diversion at the outset or at any time during their 8-day investigation leading up to the arrest. In an email to his supervisor, dated June 29, an OIG Special Agent, whose area of investigative responsibility included the Lebanon VA Medical Center, reported that he first learned of the arrest that same morning after he retrieved a telephone message left the previous day by Chief [REDACTED], Medical Center Police Chief. The Special Agent further reported that he contacted Chief [REDACTED], who told him that Mr. Callahan instructed him not to notify OIG of the suspected drug diversion until police “wrapped up” their investigation. Chief [REDACTED] (no longer with VA) told us that he advised Mr. Callahan early on in the investigation that Mr. Callahan needed to notify OIG of the possible drug diversion. Chief [REDACTED] said that Mr. Callahan told him to delay notifying OIG until VA police could establish the existence of “probable cause.”

(b)(7)(c)

Mr. Callahan told us that he did not learn of the matter until June 22 or 23, 2011, when he met with Mr. [REDACTED] Director of Quality Management, and Chief [REDACTED]; however contrary to this assertion, he also said that he “authorized a fact-finding when it was brought to [his] attention....,” which was initiated on June 21. Mr. Callahan said that Mr. [REDACTED] and Chief [REDACTED] showed him a report reflecting the medications that the Nurse administered over a 3- or 4-day period and told him that it indicated “a large usage of medication.” He said that it was not until the following Monday, June 27, that Chief [REDACTED] first told him of a need to notify OIG. He said that this was after a personnel location tracking system report provided evidence that the Nurse never entered the patient’s room, so therefore, the Nurse could not have administered the pain medications. Mr. Callahan said:

(b)(7)(c)

Up until that point, I think there were a lot of possibilities of what it could have been. One of the possibilities was indeed a criminal issue, but in my mind it didn't get to the felony stage until the Chief said "You know, we know [the Nurse is] not administering the meds. [The Nurse is] not entering the room.”

Mr. Callahan told us that prior to June 27, he did not have any discussions with Chief [REDACTED] regarding the need to notify OIG and that at no time did he (Mr. Callahan) ever tell Chief [REDACTED] not to notify or to delay in notifying OIG. He said that he was aware of the requirement to notify OIG about criminal matters from training he received several years earlier during his Senior Executive Service (SES) orientation. However, he said that the word “felony” was not used during the training but instead he said that they told him to notify the OIG of criminal matters involving “serious issues.” Mr. Callahan said

that the types of serious issues discussed were those such as “violent offense[s], bodily injury, [and] very serious drug offenses.”

Mr. [REDACTED], Associate Director, told us that on the afternoon of Monday, June 20, 2011, Ms. [REDACTED] told him that two subordinate managers told her that a nurse was suspected of diverting drugs. He said that after he discussed the matter with Ms. [REDACTED] he told Mr. Callahan’s Executive Assistant, Ms. [REDACTED] about the suspected drug diversion, and he recollected that either later that day, or the next day, he told Mr. Callahan of the matter. Ms. [REDACTED] told us that on Monday, June 20, 2011, two of her subordinate supervisors told her that they were concerned that the Nurse was involved in “medication diversion.” Ms. [REDACTED] said that a second nurse noticed that the Nurse always administered PRN medication to a specific patient; however, she said that when the second nurse was assigned to that same patient, PRN medications were not needed. Ms. [REDACTED] said that Mr. Callahan was not at the medical center that day, so she said that she immediately notified Mr. [REDACTED] of the suspected diversion of medication. She also said that she and Mr. [REDACTED] then contacted Mr. Callahan by telephone to tell him of the matter.

(b)(7)(c)

Ms. [REDACTED] said that Mr. Callahan participated by telephone or in person in subsequent discussions about the suspected drug diversion. She said that they discussed whether there was a need to make further notifications and she recalled that someone said, “At this point we really don’t know if we have an issue.” However, she said that she could not remember if Mr. Callahan or someone else said it during their discussions, but she said that she remembered that Mr. Callahan wanted Mr. [REDACTED] and Chief [REDACTED] to look into the matter further. Ms. [REDACTED] said that their discussions regarding notification “might have been [about] the IG” but that “we didn’t know if we had any criminal activity.” She further said that she later saw a report that showed “a significant spike” in the quantity of medications the Nurse administered and that the report reflected that the Nurse was “medicating this patient much more that anyone else had been.” Ms. [REDACTED] told us that she initially did not think OIG needed to be informed of the suspected drug diversion in the early stage of their inquiry, since they were unsure of the Nurse’s activities; however after she reviewed the regulation requiring notification of OIG, she said that the matter should have been referred to OIG at the outset.

(b)(7)(c)

Ms. [REDACTED] told us that she recalled first hearing about the suspected drug diversion on Tuesday, June 21, 2011, during a meeting that Ms. [REDACTED] scheduled. She said that during the meeting, Mr. Callahan told Mr. [REDACTED] and Chief [REDACTED] to look into the matter. She also said that after Mr. [REDACTED] obtained the first medication administration report, it was “obvious that there was something going on here.” She said that “as a nurse, it took my breath away, just to think that someone could claim to administer all of that medication and not actually do it.” She further said that in the early stage of the investigation, Chief [REDACTED] mentioned in a meeting that OIG needed to be notified and that at a later meeting Mr. Callahan told Chief [REDACTED] to “hold off” on notifying OIG.

(b)(7)(c)

Retrospectively, Ms. [REDACTED] told us that after reviewing more closely the regulation requiring that OIG be immediately notified of possible felony criminal activity, she said that OIG was not notified as required in this instance.

Mr. [REDACTED] told us that on June 21, after the morning leadership meeting, Ms. [REDACTED] asked several managers to stay behind to discuss the Nurse's suspected drug diversion activity. He said that Mr. Callahan and Chief [REDACTED] participated in the meeting and that Chief [REDACTED] mentioned to the group that he needed to tell OIG about the possible drug diversion. Mr. [REDACTED] also said that Mr. Callahan told him that he wanted to first get more information before notifying OIG. Mr. [REDACTED] told us that after the meeting he worked that day with his staff, and using data from the medication administration logs, he prepared a report of all medications that were administered by the Nurse and other staff on the same ward, dating back to December 2010. He said that the report reflected that the Nurse administered more medications than anyone else. Mr. [REDACTED] said that he gave daily updates to VA police which continued to reflect that the Nurse administered more medications than other staff. (b)(7)(c)

*Interference with an OIG Investigation and Failure to Testify Freely and Honestly*

Federal regulations state that employees will furnish information and testify freely and honestly in cases respecting employment and disciplinary matters. Refusal to testify, concealment of material facts, or willfully inaccurate testimony in connection with an investigation or hearing may be ground for disciplinary action. 38 CFR § 0.735-12(b). VA policy provides penalties of reprimand to removal for the intentional falsification, misstatement, or concealment of material fact in connection with employment or any investigation, inquiry or proper proceeding. VA Handbook 5021, Part I, Appendix A (April 15, 2002).

The U.S. Court of Appeals for the Federal Circuit determined that a lack of candor is a broader and more flexible concept whose contours and elements depend upon the particular context and conduct involved. It may involve a failure to disclose something that, under the circumstances, should have been disclosed in order to make the given statement accurate and complete. *Ludlum v. Department of Justice*, 278 F.3d 1280 (Fed. Cir. 2002), and also referenced within *Steverson v. Social Security Administration*, C.A.F.C. No. 2009-3287

On August 3, 2011, we notified Mr. Callahan by telephone and in a follow-up email that we were conducting an OIG administrative investigation, and we stressed the importance of maintaining the integrity of the investigation. We told him to not discuss our investigation, to include the allegations, with anyone from his staff. We also cautioned him to avoid any actions that might give an appearance that he was interfering with or attempting to unduly influence our investigation. On August 23, Mr. Callahan told us that he did not communicate with his staff regarding our investigation; however, he said,

“The only thing that I have done with my staff in preparation for this is ask for copies of the issue brief, and of the police UOR, to review that, to refresh myself.”

Contrary to Mr. Callahan’s assertion that he did not communicate with his staff about our investigation, Mr. ██████ told us that on August 19, after OIG contacted him to schedule an interview in connection with our investigation, he told Mr. Callahan that he would be meeting with OIG. Mr. ██████ said that Mr. Callahan then mentioned the Nurse’s name and told him that OIG probably wanted to talk to him about that matter. Mr. ██████ also said that Mr. Callahan then asked him to recount various events that occurred during the medical center’s investigation of the Nurse and that in their discussion, he provided Mr. Callahan with details of what he knew about the events that took place. Mr. ██████ further said that during his conversation with Mr. Callahan, he mentioned that he was preparing a written timeline of the events to prepare for his OIG interview and that Mr. Callahan asked him for a copy of it. Mr. ██████ told us that he provided a copy of his timeline to Mr. Callahan.

In addition, Mr. Callahan told us that he was not told of the Nurse’s “possible medication management issues” until June 22 or 23, when he first met with Mr. ██████ and Chief ██████. He reiterated this even when asked about the IB that reflected he requested the investigation on June 21. The IB reflected that “An investigation into the on duty activities of a Lebanon VAMC employee was conducted at the request of medical center Executive Leadership (Director and Associate Director, Patient Care Services) on June 21, 2011.” Mr. Callahan told us that the statement pertaining to the Director requesting the investigation was factually incorrect, because he said that he did not know about the issue until after June 21. He said that the IB was written at a time when he was away from the medical center on leave. However, Mr. ██████ and Ms. ██████ told us that Mr. Callahan was notified about the Nurse’s suspected drug diversion by telephone on or about June 20. Further, Mr. Callahan told us that he never instructed Chief ██████ to delay notifying OIG and that it was not until Monday June 27 that Chief ██████ first told him that OIG should be notified. However, Chief ██████, Ms. ██████, and Mr. ██████ all told us that it was as early as June 21 that Chief ██████ told Mr. Callahan that OIG needed to be notified and that Mr. Callahan directed that OIG not be notified until more information about the suspected drug diversion was obtained. (b)(7)(c)

In a June 23, 2011, email between Chief ██████ and a VA Police Detective, they discussed contacting the U.S. Attorney’s Office about obtaining a search warrant in connection with their investigation of the Nurse. Mr. Callahan told us that he “was not aware of it at that time.... That's an inner working to the police department that I don't have knowledge of, don't know.” However contrary to his assertion, email records reflected that Mr. Callahan was directly involved in a June 23 email exchange, along with Chief ██████, Mr. ██████, Ms. ██████, and the Human Resources Director discussing employee searches, probable cause to obtain a search warrant, and the legal authority to conduct searches without a warrant. In this email string, Mr. Callahan opined that the

police could not legally conduct a warrantless search of an employee but that a supervisor could if there was “reasonable suspicion.”

### *Insufficient Policy and Training Related to Notification Requirements*

VA policy requires that each VA facility publish a standard operating procedure (SOP) that is consistent with VA SLE policy and Federal laws and regulations. VA Handbook 0730, Paragraph 5(a). VA policy regarding serious incident reports requires any adverse event that is likely to result in National media or Congressional attention establishes nine criteria for the implementation for a serious incident report. VA Directive 0321 (November 5, 2010). We found that six of the nine reporting criteria are also reflected in the OIG notification requirements found in 38 CFR § 1.204. The remaining three, while not addressed in this regulation, are nonetheless types of events that would be of interest to OIG. However, we found that these VA policies did not contain specific language reflecting a requirement to notify OIG immediately of possible criminal activity involving a felony as reflected in 38 CFR § 1.204.

Further, we found that the Lebanon VA Medical Center internal policy (MCM 07B-01, September 2, 2008), as well as a review of those at several other medical centers, did not contain sufficient reference to the requirements found in 38 CFR § 1.204 to immediately notify OIG of possible felony criminal activity. In one instance, we found that a VA facility’s local policy required reporting a crime scene involving a death to the Federal Bureau of Investigation and their local police department, but it did not require that the crime be reported to OIG. In addition, VA Medical Center Management Officials, to include Mr. [REDACTED], Ms. [REDACTED], Ms. [REDACTED] and Mr. [REDACTED] told us that they were not familiar with the requirement to immediately notify OIG whenever they learned of possible felony criminal activity. (b)(7)(c)

## **Conclusion**

We concluded that Mr. Callahan violated Federal regulations when he failed to ensure that information about a possible felony crime (drug diversion) was immediately referred to OIG Office of Investigations. Once clinical staff reported the initial information about the Nurse’s suspected drug diversion to senior management, Mr. [REDACTED] and Ms. [REDACTED] notified Mr. Callahan soon thereafter. Despite being advised by his subject matter expert, Chief [REDACTED], that the matter needed to be immediately referred to OIG, and despite his training to follow such advice, Mr. Callahan chose not to allow prompt notification to OIG, wanting instead to have the matter investigated internally by medical center staff. We do not find credible Mr. Callahan’s assertion that it was not until June 27, after learning that the Nurse never entered the patient’s room, that he realized that this constituted a possible felony and required notifying OIG. Mr. Callahan had enough information when first informed of the suspected drug diversion for a reasonable person

to conclude that it was a possible felony crime. He did not need to conclude that one occurred, only the possibility of one.

We also found that Mr. Callahan interfered with an OIG investigation when he engaged in an inappropriate conversation with a member of his staff about our investigation; and, was less than candid when asked if he had any such conversations with his staff. Four days before his OIG interview, Mr. Callahan discussed our investigation with Mr. [REDACTED] and asked him to provide key information about events that he reasonably knew OIG would ask him about during his interview. Then, during his interview when asked directly about any communications he had with his staff concerning our investigation, Mr. Callahan did not tell us about his conversation with Mr. [REDACTED]

Further, we found that Mr. Callahan was less than candid during his interview regarding when he first learned about the suspected drug diversion; when he was told of a requirement to notify OIG; whether he told Chief [REDACTED] to delay notifying OIG; and, whether and when he knew of Chief [REDACTED] seeking a search warrant. We did not find credible Mr. Callahan's assertion that he first learned about the suspected drug diversion after June 21. We found the corroborating testimonies of Mr. [REDACTED] and Ms. [REDACTED] that they told Mr. Callahan about the matter on or about June 20 to be more credible. In addition, Mr. Callahan falsely told us that he never told Chief [REDACTED] to delay notifying OIG and that Chief [REDACTED] first advised him on June 27 that OIG needed to be notified. We found more credible the corroborating testimonies of Chief [REDACTED] Ms. [REDACTED], and Mr. [REDACTED] reflecting that Chief [REDACTED] mentioned early on a need to notify OIG and that Mr. Callahan told him to delay. (b)(7)(c)

Moreover, we did not find credible Mr. Callahan's assertion that he did not know about Chief [REDACTED]'s desire as early as June 23, to obtain a search warrant. Email records showed that on June 23, Mr. Callahan not only engaged in an email discussion with managers involved in the internal investigation regarding employee searches, probable cause to obtain a search warrant, and the legal authority to conduct searches without a warrant, but he also provided his professional opinion on the matter.

Finally, we found that VA policy and many VA Medical Centers' internal policy did not contain sufficient reference to the requirement to immediately notify OIG of possible criminal activity involving a felony. We stress that compliance with the obligation to immediately notify OIG does not override the need to contact other local law enforcement as appropriate to the situation for immediate response. We further found that VA Management Officials were insufficiently trained on the requirement to immediately notify OIG in such circumstances.

**Recommendation 1.** We recommend that the Deputy Under Secretary for Health for Operations and Management (DUSHOM), confer with the Office of Human Resources (OHR) and the Office of General Counsel (OGC) to determine the appropriate administrative action to take against Mr. Callahan and ensure that action is taken.

**Recommendation 2.** We recommend that the DUSHOM ensure that each Veterans Health Administration (VHA) facility's local policy contains language reflecting the OIG notification requirements found in 38 CFR § 1.204.

**Recommendation 3.** We recommend that the DUSHOM ensure that all VHA Management Officials receive training on the requirement to notify OIG *immediately* of any *possible* felony criminal activity.

**Recommendation 4.** We recommend that the Assistant Secretary for Operations, Security, and Preparedness ensure that VA policy, to include VA Handbook 0730 and VA Directive 0321, are amended to add the specific language as reflected in 38 CFR § 1.204 requiring VA Management Officials to ensure OIG Office of Investigations is immediately notified of any possible felony criminal activity.

## Comments

The Deputy Under Secretary for Health for Operations and Management and the Assistant Secretary for Operations, Security, and Preparedness were responsive, and their comments are in Appendix A and B, respectively. VA provided proposed amendments to policies cited in recommendation 4, and OIG concurred in those proposed amendments. We will follow up to ensure that all the recommendations are fully implemented.



JAMES J. O'NEILL  
Assistant Inspector General for  
Investigations

## Deputy Under Secretary Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 23, 2012

**From:** Deputy Under Secretary for Health for Operations and Management (10N)

**Subject:** **Administrative Investigation, Failure to Properly Report a Felony to OIG, Interference with an OIG Investigation, and Lack of Candor, Lebanon VA Medical Center, Pennsylvania**

**To:** Assistant Inspector General for Investigations (51)

1. The draft report, including the findings and conclusions, has been reviewed carefully.
2. Reporting by Veterans Integrated Service Networks (VISN) and Department of Veterans Affairs Medical Centers (VAMC) of criminal matters in accordance with Title 38 C.F.R. 1.204 about potential felony activities is a crucial element of Veterans Health Administration (VHA) operations and a matter that I take very seriously. The attached corrective action plan describes how we will address potential administrative actions involving individuals in regard to the particular instances of concern.
3. Also, I issued a memorandum on March 7, 2012, emphasizing that it is the responsibility of the management team in VAMCs to establish standard operating procedures (SOP) that conform to VA policies relating to the prompt reporting of felonies and suspected felonies to VA Law Enforcement Officials and to the Office of Inspector General (OIG), to ensure that VAMC management staff are trained on these policies, and to ensure that these SOPs are enforced.

4. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.



William C. Schoenhard, FACHE

Attachment

## **Deputy Under Secretary's Comments to Office of Inspector General's Report**

The following Deputy Under Secretary's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

### **OIG Recommendation(s)**

**Recommendation 1.** We recommend that the Deputy Under Secretary for Health for Operations and Management (DUSHOM), confer with the Office of Human Resources (OHR) and the Office of General Counsel (OGC) to determine the appropriate administrative action to take against Mr. Callahan and ensure that action is taken.

**Comments:** The DUSHOM will confer with OHR and OGC to obtain guidance regarding whether administrative action, if any, should be initiated. We will notify you by July 1, 2012, about responses from OHR and OGC and any actions taken.

**Recommendation 2.** We recommend that the DUSHOM ensure that each Veterans Health Administration (VHA) facility's local policy contains language reflecting the OIG notification requirements found in 38 CFR § 1.204.

**Comments:** In order to ensure uniformity in reporting across the Veterans Health Administration (VHA), the DUSHOM issued a memorandum on March 7, 2012, to the 21 Veterans Integrated Service Network (VISN) Directors emphasizing the requirement and need for timely reporting of criminal matters by VISNs and Department of Veterans Affairs Medical Centers (VAMC) in accordance with 38 CFR §1.204. The memorandum included provisions for VISN Directors to confirm that Standard Operating Procedures adequately conform to VA policy. VISN Directors are to confirm this has been completed by April 7, 2012.

**Recommendation 3.** We recommend that the DUSHOM ensure that all VHA Management Officials receive training on the requirement to notify OIG immediately of any possible felony criminal activity.

**Comments:** In order to ensure additional training across VHA concerning reporting to OIG, the DUSHOM memorandum issued on March 7, 2012, to the 21 VISN Directors included provisions for VAMC managers to receive training about reporting incidents to the Office of Inspector General (OIG). VISN Directors are to confirm completion of training by May 7, 2012.

## Assistant Secretary Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 20, 2012

**From:** Assistant Secretary for Operations, Security, & Preparedness  
(007)

**Subject:** **Response to OIG Recommendation #4** - Administrative Investigation, Failure to Properly Report a Felony to OIG, Interference with an OIG Investigation, and Lack of Candor, Lebanon VA Medical Center, PA (Draft 2011-03720-IQ-0196). (VAIQ 7210056)

**To:** Inspector General (50)

1. This memorandum is in response to OIG's Report entitled "Administrative Investigation, Failure to Properly Report a Felony to IG, Interference with an IG Investigation, and Lack of Candor, Lebanon VA Medical Center, PA."
2. In the investigation leading to this report, the IG noted that there is no VA policy implementing regulatory requirements found in 38 C.F.R. – *Referrals of Information Regarding Criminal Violations*, to report suspected felony offenses to the IG.
3. In recommendation #4 resulting from this report, the IG recommends the Office of Operations, Security, and Preparedness amends existing policies (VA Directives 0730 and 0321) to reflect this requirement.
  - In order to meet recommendation #4, OSP is updating VA Directive 0321, Serious Incident Reports, with the language from the existing regulations in 38 C.F.R. 1.200, 1.201, 1.203, and 1.204.

- In order to meet recommendation #4, OSP is updating VA Directive 0730, Security and Law Enforcement, with the language from the existing regulations in 38 C.F.R. 1.201, 1.203, and 1.204.
4. In accordance with VA Directives Management guidelines we anticipate VA staff office concurrence and VA Directive Management final review process to be completed by July 20, 2012.
  5. Should you have any questions, please feel free to contact Sylvia Dunn at 202-461-4984.

  
Jose D. Riojas

**Assistant Secretary's Comments  
to Office of Inspector General's Report**

The following Assistant Secretary's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommendation 4.** We recommend that the Assistant Secretary for Operations, Security, and Preparedness ensure that VA policy, to include VA Handbook 0730 and VA Directive 0321, are amended to add the specific language as reflected in 38 CFR § 1.204 requiring VA Management Officials to ensure OIG Office of Investigations is immediately notified of any possible felony criminal activity.

**Comments:** See comments.

## OIG Contact and Staff Acknowledgments

---

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Charles Millard

---

## Report Distribution

### VA Distribution

Deputy Secretary (001)  
Chief of Staff (00A)  
Executive Secretariat (001B)  
Under Secretary for Health (10)  
Principal Deputy Under Secretary for Health (10A)  
Deputy Under Secretary for Health for Operations and Management (10N)  
Assistant Secretary for Operations, Security, and Preparedness (007)  
Management Review Service (10A4A4)

### **To Report Suspected Wrongdoing in VA Programs and Operations:**

**Telephone: 1-800-488-8244**

**E-Mail: [vaoighotline@va.gov](mailto:vaoighotline@va.gov)**

**Hotline Information: [www.va.gov/oig/hotline/default.asp](http://www.va.gov/oig/hotline/default.asp)**