VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Department of Veterans Affairs

Review of Alleged Unauthorized Devices and Equipment on Networks at the Southern Arizona VA Health Care System

January 7, 2016
14-04979-11

Why We Did This Review

We conducted this review to determine the merit of an anonymous Hotline allegation received in July 2014 that a large unauthorized network was operating at the Southern Arizona VA Health Care System (SAVAHCS), in Tucson, AZ. The allegation stated that this network was isolated from the local VA campus network and contained a multitude of unauthorized biomedical devices and other improperly installed equipment.

What We Concluded

We substantiated the allegation that there were unauthorized devices on the SAVAHCS networks. In September 2014, we requested information from the VA Health Information Security Division, Network Security Operations Center (NSOC), Office of Information and Technology (OI&T) Region 1, and SAVAHCS personnel to evaluate the merit of the allegation. In November 2014, we performed an on-site review of the SAVAHCS for unauthorized biomedical equipment and networks. Additionally, we reviewed documentation and business process controls related to proper authorization and use of biomedical equipment and networks.

During the course of our review, we determined that several months prior to the Office of Inspector General's (OIG) receipt of the Hotline allegation, OI&T Region 1 staff had become aware of the operation of the biomedical network. OI&T Region 1 personnel did not have oversight or control of this local network. OI&T initiated a review, during which they discovered that SAVAHCS biomedical engineers and network specialists maintained the biomedical network. Subsequently, the NSOC reported this security incident and OI&T staff performed an on-site security review of the unauthorized biomedical network.

OI&T's security review concluded that there was no interconnection between the biomedical network and the SAVAHCS's network infrastructure. The biomedical network supported a variety of authorized activities, such as providing patient tracking services, physical security access control, security camera monitoring, radiation waste storage detection, and Internet access for residents at the SAVAHCS's Blind Rehabilitation Center. Further, systems hosted on the biomedical network did not process sensitive patient data or personally identifiable information as defined by VA policy.

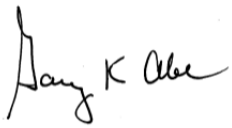
OI&T Region 1 assumed full configuration control of the biomedical network and authorized the network to operate in support of patient services. In light of OI&T's actions, we have no recommendations.

Supplemental Data

We requested information from VA's Health Information Security Division, NSOC, OI&T Region 1, and SAVAHCS personnel to evaluate the merit of the allegation. We conducted an on-site review at the SAVAHCS to test for unauthorized biomedical equipment and networks. Additionally, we reviewed documentation and business process controls related to proper authorization and use of biomedical equipment and networks.

We complied with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluations to the extent possible. The evidence to review the allegations consisted of interviews, program documentation, processes, and controls related to the allegation. Because OI&T identified the unauthorized network several months prior to the OIG's receipt of the Hotline allegation, our review and testing was limited.

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



GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

Report Distribution

VA

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel

NON-VA

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Flake, John McCain
U.S. House of Representatives: Trent Franks, Ruben Gallego, Paul A. Gosar, Raul Grijalva, Ann Kirkpatrick, Martha McSally, Matt Salmon, David Schweikert, Kyrsten Sinema

This report is available on our Web site at www.va.gov/oig.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/contacts/hotline.asp)