



Department of Veterans Affairs

Office of Inspector General

April 2014 Highlights

CONGRESSIONAL TESTIMONY

Office of Inspector General Tells Congress Unexpected Deaths Could Be Avoided if Veterans Health Administration Focused First on Core Health Care Mission

Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States House of Representatives, on recent reports by the Office of Inspector General (OIG) that point to issues related to the quality of care provided at some VA facilities that may have resulted in unexpected deaths. Dr. Daigh focused on reports related to delays in scheduling consult exams, introduction of new technology without adequate regard to patient safety, and disregard for routine VA policies and procedures. While recognizing that no two facilities are the same, Dr. Daigh stressed that it would be beneficial to VA to review the organizational structure and business rules of the Veterans Health Administration (VHA) to determine if changes would make the delivery of quality health care the priority and reduce the potential for errors. [\[Click here to access testimony.\]](#)

ADMINISTRATIVE INVESTIGATION

VA Medical Center Director and Equal Employment Opportunity Program Manager Failed To Comply with Americans with Disabilities Act and VA Policy

A VA Medical Center (VAMC) Director failed to meet reasonable accommodations (RA) confidentiality requirements by disclosing an employee's confidential medical information to unauthorized VA managers, medical staff, and other employees. In addition, the Director improperly appointed herself Designated Management Official (DMO), substituted her medical judgment for that of an employee's physicians, delayed accommodating the employee while gathering additional, unnecessary medical information, and neglected to provide the employee avenues of redress when she denied the employee's RA request. Further, the VAMC Equal Employment Opportunity Program Manager and Local Reasonable Accommodations Coordinator (LRAC) failed to implement the *Americans with Disabilities Act Amendments Act of 2008* and subsequent Equal Employment Opportunity Commission guidance, after receiving directions from VA's Office of Diversity and Inclusion. The LRAC violated confidentiality requirements when she consulted VHA physicians and revealed the nature of the employee's condition to the DMO and others and failed to follow VA policy when she composed an RA denial letter without providing avenues of redress for the VA employee. Further, a Regional Counsel Staff Attorney failed to provide proper advice to the LRAC concerning the employee's prospective RA, as she told the LRAC that RA guidelines did not recognize the employee's medical condition as a disability.

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

OIG REPORTS**OIG Finds Questionable Cardiac Interventions, Poor Management of Cardiovascular Care at Hines, Illinois, VAMC**

OIG conducted an inspection at the Edward Hines, Jr. VA Hospital in Hines, IL, at the request of Senator Richard Durbin and Congresswoman Tammy Duckworth concerning unnecessary cardiac interventions and poor management of cardiovascular care. OIG substantiated that two patients had questionable indications for coronary bypass surgery and that preoperative planning was inadequate for a patient who underwent coronary artery bypass surgery. OIG found that coronary interventions may have been inappropriate for nine patients who had undergone cardiac catheterizations during 2010–2013. OIG substantiated that there were operating room environmental and equipment deficiencies, hospital beds were often unavailable, there was poor bed utilization, and the facility did not monitor compliance with two of an affiliated academic institution's contracts. OIG did not substantiate that a patient who died in the operating room received inappropriate care, the operation should not have been performed at the facility, and that preoperative planning was inadequate. OIG did not substantiate that there was inadequate staffing or medical support for cardiac surgery, patients had excessively long waits to be admitted from the emergency department, there were delays in or poor quality of echocardiography, non-board certified physicians were assigned to crucial management positions, care was inappropriately provided by trainees and non-physician providers, staff failed to adhere to written policies for the Surgical Intensive Care Unit, and that Surgical Intensive Care Unit physicians sometimes were at an affiliated academic institution during their VA tours of duty, or that there was a lack of fairness of Administrative Investigation Boards. OIG made four recommendations. [\[Click here to access report.\]](#)

OIG Finds No Relationship Between Length of Patient's Emergency Department Wait and Subsequent Clinical Course at Southern Nevada Healthcare System

OIG conducted an inspection at the VA Southern Nevada Healthcare System (HCS), Las Vegas, NV, in response to a request from the House Committee on Veterans' Affairs Chairman Jeff Miller and Congresswoman Dina Titus. OIG evaluated the merit of allegations that a patient experienced an excessive wait for emergency care and that staff repeatedly disrespected the patient. OIG found that in October 2013, an elderly patient spent 5 hours and 6 minutes in the facility's emergency department (ED), waiting 4 hours and 45 minutes to be evaluated by an ED physician. OIG concluded that a wait of this length was challenging for this patient. However, mitigating this long wait was the fact that numerous other patients who were assessed to be in more urgent need of attention were in the ED at the same time. The facility's target is for less than 10 percent of its ED patients to experience a total ED length of stay of greater than 6 hours. The facility met this target on only 1 day during the week in which the patient visited the ED. The purpose of triage in the ED is to prioritize incoming patients and to identify those who cannot wait to be seen. The patient's wait time to be triaged by a registered nurse was 63 minutes. During the patient's multi-hour waiting period, there was no documentation of hourly nursing reassessments as required by local policy. OIG found no relationship between the length of the patient's ED wait and her subsequent clinical course. OIG did not substantiate the allegations of staff disrespect. OIG made two recommendations. [\[Click here to access report.\]](#)

Charleston, South Carolina, VAMC Split Purchases and Made Unauthorized Commitments with Government Purchase Cards

OIG conducted this audit in response to an allegation received through the VA OIG Hotline Division that the Engineering Service employees at the Ralph H. Johnson, VAMC, Charleston, SC, were splitting purchases to circumvent the \$3,000 micro-purchase limit. OIG expanded its review to determine the extent Engineering Service employees inappropriately used purchase cards from October 2011 through May 2013. OIG substantiated the allegation that Charleston VAMC Engineering Service employees split purchases and identified improper purchase card payments. OIG sampled 139 purchases Engineering Services made during the period of October 2011 through May 2013, and found 40 were unauthorized commitments totaling \$83,100 that avoided competition requirements. The 40 unauthorized commitments included 35 purchases valued at about \$69,300 that cardholders split, and 5 purchases valued at about \$13,800 that exceeded the micro-purchase limit for services. Engineering Service employees also made 33 purchases that OIG could not determine whether payments were appropriate because of insufficient documentation. The value of these improper payments was about \$55,000. This occurred due to ineffective oversight of cardholder transactions and inadequate purchase card training of approving officials and cardholders. As a result, OIG estimated that Charleston VAMC's Engineering Service cardholders made about \$274,000 in unauthorized commitments and approximately \$372,000 of purchases that lacked sufficient documentation. OIG recommended the Veterans Integrated Service Network (VISN) 7 Director review Charleston VAMC Engineering Service's purchase card transactions for unauthorized commitments and purchases lacking sufficient documentation and process necessary ratification and payment recovery actions. Additionally, OIG recommended the VISN 7 Director improve purchase card practices by developing a process to ensure improved oversight and provide sufficient training. The VISN 7 Director concurred with the recommendations and provided an acceptable action plan. [\[Click here to access report.\]](#)

VA Improved Compliance with Improper Payment Reporting, More Work Needed by Veterans Benefits Administration and VHA To Reduce Improper Payments

VA reported \$1.1 billion in improper payments in its fiscal year (FY) 2013 Performance and Accountability Report (PAR). The OIG's assessment of VA's compliance with the *Improper Payments Elimination and Recovery Act* (IPERA) for FY 2013 is based on FY 2012 data as reported by VA. OIG conducted this FY 2013 review to determine whether VA complied with the IPERA. OIG found VA implemented a new risk assessment process in FY 2013 across all of its programs, and met five IPERA requirements for FY 2013 by publishing a PAR, performing risk assessments, publishing improper payment estimates, providing information on corrective action plans, and reporting on its payment recapture efforts. However, VA did not comply with two of seven IPERA requirements for FY 2013. This represents an improvement over FY 2012, when VA was not in compliance with four of the seven IPERA requirements. This year, OIG identified areas for improvement in both the Veterans Benefits Administration (VBA) and VHA's IPERA reporting. VBA underreported improper payments for its Compensation program. Test procedures for the Compensation program and one Education program also did not include steps needed to identify all types of improper payments. VHA reported a gross improper payment rate of greater

than 10 percent for one program and did not meet reduction targets for two programs. OIG recommended the Under Secretary for Benefits ensure thorough procedures for testing sample items used to estimate improper payment for the Compensation and Post 9/11 G.I. Bill programs. OIG also recommended the Under Secretary for Health implement the corrective action plan included in the PAR to reduce improper payments for the State Home Per Diem program, and develop achievable reduction targets for that and Beneficiary Travel program. OIG will follow up on implementation of the proposed action plans during OIG's next annual IPERA review.

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

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Combined Assessment Program Reviews

In April 2014, the Office of Healthcare Inspections published seven Combined Assessment Program (CAP) reviews containing OIG findings for the medical centers and health care systems listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations and to provide crime awareness briefings. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following seven activities: (1) quality management, (2) environment of care (EOC), (3) medication management (MM), (4) coordination of care, (5) nurse staffing, (6) pressure ulcer prevention and management, and (7) community living center Resident Independence and Dignity (excluding the Birmingham VAMC).

[Northern Indiana HCS, Fort Wayne, Indiana](#)

[Lebanon VAMC, Lebanon, Pennsylvania](#)

[Birmingham VAMC, Birmingham, Alabama](#)

[Southern Arizona HCS, Tucson, Arizona](#)

[Loma Linda HCS, Loma Linda, California](#)

[Portland VAMC, Portland, Oregon](#)

[Caribbean HCS, San Juan, Puerto Rico](#)

Community Based Outpatient Clinic Reviews

In April 2014, the Office of Healthcare Inspections published five Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities: (1) EOC, (2) alcohol use disorder, (3) MM, and (4) designated women's health provider proficiency.

[Birmingham VAMC, Birmingham, Alabama](#)

[Southern Arizona HCS, Tucson, Arizona](#)

[El Paso HCS, El Paso, Texas](#)

[Northern Indiana HCS, Fort Wayne, Indiana](#)

[Lebanon VAMC, Lebanon, Pennsylvania](#)

CRIMINAL INVESTIGATIONS

Former Palo Alto, California, VAMC Employee Pleads Guilty to Bribery

A former Palo Alto, CA, VAMC employee pled guilty to bribery. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the former employee, a contracting officer representative, accepted bribes, including cash and car payments, in exchange for ensuring that VA contractors received continuous work. The defendant received approximately \$32,400 in bribes and gifts. As a result of the same investigation, a former VA contractor pled guilty to providing a gratuity to a public official. The investigation revealed that the contractor gave gifts and cash valued at \$143,068. The gifts included vehicles, paying for personal travel expenses, and working on the home of a VA employee.

VA Contractor Indicted for Bribery and Providing Gratuities

An OIG and FBI investigation revealed that from July 2009 to March 2011 a VA contractor paid bribes and gratuities to a Sacramento, CA, VA contracting officer. The contractor provided the contracting officer with cash payments, Disneyland tickets, and hotel accommodations that were worth approximately \$43,400. In exchange for the payments, the contractor received 27 VA contracts and task orders worth approximately \$7.4 million.

Former Salisbury, North Carolina, VAMC Police Officer Indicted for Attempted Robbery

A former Salisbury, NC, VAMC police officer was indicted for attempted robbery of a credit union located on the campus of the VAMC. An OIG and FBI investigation revealed that while on duty, the defendant attempted to rob the credit union by forcing a credit union employee into the building as she was opening for the day. The defendant concealed his identity by wearing overalls, a ski mask, and gloves. Two construction workers witnessed the incident and chased the defendant as he fled from the scene. The defendant evaded the workers by hiding in a Heating, Ventilation, and Air Conditioning (HVAC) room, exiting in his uniform, and assisting in the search for the "suspect." Later that day, a duffel bag containing items worn during the attempted robbery was located in the locked HVAC room. The defendant returned a few days later to retrieve the duffel bag and was captured on surveillance video. The defendant confessed during an interview and agreed to surrender himself after indictment.

Long Beach, California, VAMC Employee Charged with Theft of Government Funds

A criminal information was filed against a Veteran, who was also a full-time Long Beach, CA, VAMC employee, for theft of Government funds. An OIG investigation revealed that while employed at the VAMC the defendant applied for and received approximately \$60,746 in VA pension benefits without disclosing that between 2007 and 2011 he earned approximately \$155,097 in wages.

Construction Company Owners Enter into Pretrial Diversion Agreements

Two brothers, the current owners of an established construction company, entered into separate pretrial diversion agreements with a U.S. Attorney's Office relating to their role in establishing a sham Service-Disabled Veteran-Owned Small Business (SDVOSB). As part of the agreement, the defendants are required to pay VA restitution of \$195,000 and have agreed to a 3-year debarment, both individually and as a company, from any Government contracts. The defendants are also to be supervised by U.S. Probation and Pretrial Services for 12 months. An OIG and FBI investigation determined that the defendants served as officers of the SDVOSB, provided start-up capital, and secured bonding for the stepson of one of the brothers. The stepson served as the majority owner of the SDVOSB, although the two defendants maintained control of the business. The defendants then used the sham company as a pass through for the established company to secure SDVOSB set-aside contracts. The SDVOSB obtained almost \$13.5 million in set-aside contracts.

Former Salisbury, North Carolina, VAMC Nursing Assistants Charged With Assault

A former Salisbury, NC, VAMC nursing assistant was charged in a criminal information with the assault of an elderly dementia patient at the VAMC. An OIG investigation revealed the defendant struck the patient under his eye and attempted to conceal her actions by leaving the scene. The defendant subsequently confessed to striking the patient. Another former Salisbury, NC, VAMC nursing assistant was charged in a criminal information with assault of an elderly dementia patient at the VAMC. An OIG investigation revealed that after being struck by the patient, the defendant became angry, wrapped the patient's arm around his neck, and pulled him down the hallway to his room and then forced him into his bed. Prosecution was declined on a second nursing assistant who admitted to restraining the same patient to his wheelchair by stretching the patient's sleeves of his t-shirt over the handles of the wheelchair. Both employees resigned from their positions as a result of this investigation.

Veteran Indicted for Assault at Waco, Texas, VAMC

A Veteran was indicted for assault after an OIG investigation revealed that he struck a Waco, TX, VAMC police officer in the mouth, resulting in injuries.

Veteran Arrested for Assault at Long Beach, California, VAMC

A Veteran was arrested for assault, vandalism, and battery after an OIG and VA Police Service investigation revealed that while he was a patient at the Long Beach, CA, VAMC he assaulted a nurse, punched and kicked another patient, and ripped a water fountain off the wall.

Former Seattle, Washington, VAMC Employee Sentenced for Making Threat

A former Seattle, WA, VAMC employee was sentenced to 364 days' incarceration (suspended), 30 days in a community work program, 12 months' probation, and ordered to pay \$2,722 in restitution and to have no contact with VA after pleading guilty to threatening to bomb the VAMC. An OIG and VA Police Service investigation determined that the defendant wrote two letters indicating that multiple bombs would detonate somewhere in the hospital within 2 weeks. No bombs or improvised explosive

devices were found. The defendant later admitted that he wrote the letters as a diversionary tactic in an attempt to delay an investigation regarding his misuse of a Government fuel credit card.

Veteran Arrested for Making Threats to Roanoke, Virginia, VA Regional Office

A Veteran was arrested for making threats to do bodily harm. An OIG investigation revealed that the defendant told a VA Call Center that he was going to get a gun and shoot employees at the Roanoke, VA, VA Regional Office.

Veteran Arrested for Making Terroristic Threats to Long Beach, California, VAMC

A Veteran was arrested for making terroristic threats after an OIG investigation revealed that he threatened to get a weapon and shoot his VA doctor and other employees at the Long Beach, CA, VAMC. The defendant claimed that he was frustrated because he could not get his medications. In 2010, the same Veteran threatened to kill the San Antonio, TX, VAMC Director.

Veteran Arrested for Making Threats

A Veteran was indicted and arrested for making threats towards VA staff, VA facilities, and a VA-assigned fiduciary. An OIG and Federal Protective Service investigation revealed that in June 2013 the defendant made threats to use an explosive device and a firearm to kill VA employees and his VA fiduciary in order to get his VA benefits.

Veteran Arrested for Making Threats to Long Beach, California, VAMC Staff

A Veteran was arrested for making terroristic threats after an OIG and VA Police Service investigation revealed that he threatened to kill a Long Beach, CA, VAMC physician, the physician's family, and three VA police officers. The defendant made the threats because he wanted more narcotics. Also, an assault rifle was seized from the Veteran's residence.

Kerrville, Texas, VAMC Employee Arrested for Receipt of Child Pornography

A Kerrville, TX, VAMC employee was arrested for receipt of child pornography. An OIG investigation revealed that while the defendant was working a midnight shift he regularly searched for and downloaded child pornography using the VA computer in his work area. The defendant admitted to routinely engaging in similar conduct while at home and gave consent for FBI agents to conduct a search of his residence and personal computer.

Two Non-Veterans Arrested for Robbery

Two non-Veterans were arrested for the armed robbery of a VA employee at the Memphis, TN, VAMC. An OIG, VA Police Service, and local police investigation revealed that the defendants stole the employee's backpack at gunpoint in the VAMC parking lot.

Federal Judge Gives 7.5 Year Sentence to Florida Man for Identity Theft that Victimized Veterans at Haley VAMC

A non-Veteran was sentenced to 90 months' incarceration, 48 months' supervised release, and ordered to pay \$418,723 in restitution after pleading guilty to aggravated identity theft and theft of Government funds. An OIG, Internal Revenue Service Criminal Investigation (IRS-CI), and local police investigation revealed that the defendant, a convicted murderer, used Veterans' personally identifiable information (PII) from stolen Tampa, FL, VAMC medical records to file \$418,723 in fraudulent tax returns.

Non-Veteran Indicted on Multiple Fraud Charges

A non-Veteran was indicted for conspiracy to commit mail and wire fraud, aggravated identity theft, and firearm charges. An OIG, IRS-CI, Bureau of Alcohol, Tobacco, Firearms and Explosives, and local police investigation revealed that the defendant used Veterans' PII obtained from stolen VAMC medical records and other sources to file approximately \$3.1 million in fraudulent tax returns. Also, the defendant, who is a convicted felon, was in possession of multiple firearms.

OIG Investigation Results in 2 Years in Prison for Woman Who Squandered \$364K in Grants Meant for Homeless Veterans

A Veteran was sentenced to 24 months' incarceration, 2 years' supervised release, and ordered to pay \$364,000 in restitution after pleading guilty to making false material statements and theft of Government funds. An OIG investigation revealed that the defendant fraudulently obtained three separate grants from the VA Grant and Per Diem Program. The grants were intended to provide housing and assistance to homeless Veterans. However, the defendant used the grant funds for personal gain. During the execution of a search warrant at the defendant's residence, large amounts of lottery tickets, gambling slips, and other gambling paraphernalia were found.

Veteran Sentenced for Drug Distribution

A Veteran was sentenced to 66 months' incarceration and 36 months' supervised release after pleading guilty to selling his VA prescribed narcotics to a co-conspirator. The defendant was also ordered to be released to immigration officials following his incarceration for potential deportation.

St. Louis, Missouri, VAMC Nurse Indicted for Drug Diversion

A St. Louis, MO, VAMC registered nurse was indicted for health care fraud and aggravated identity theft. An OIG investigation revealed that the defendant diverted Dilaudid from patients in the emergency room for personal use.

Gainesville, Florida, VAMC Nurse Charged with Drug Diversion

A Gainesville, FL, VAMC registered nurse was charged with fraudulently acquiring controlled substances. An OIG investigation revealed that on multiple occasions the defendant removed hydromorphone from the VAMC's Pyxis machines for personal use.

Gainesville, Florida, VAMC Medical Support Assistant Arrested for Drug Diversion

A Gainesville, FL, VAMC medical support assistant was arrested for fraudulently acquiring controlled substances. An OIG investigation revealed that the defendant intentionally removed and ingested wasted controlled substances from sharps containers.

Former Nashville, Tennessee, VAMC Supervisory Pharmacist Sentenced for Drug Theft

A former Nashville, TN, VAMC supervisory pharmacist was sentenced to 1 year of supervised probation after pleading guilty to theft over \$500 and official misconduct. An OIG investigation revealed that the defendant diverted large amounts of drugs from the VAMC when she was employed as the night shift supervisor.

Former Philadelphia, Pennsylvania, VAMC Cooperative Student Arrested for Prescription Fraud

A former Philadelphia, PA, VAMC cooperative student, who is a Veteran and a former VA employee, was arrested for the theft and use of a VA employee's prescription pad. An OIG and State investigation revealed that the defendant stole a VA employee's prescription pad, forged the signature of the VA employee, and used the prescriptions to obtain various controlled medications at retail pharmacies.

U.S. Postal Service Postmaster Arrested for Theft of VA Drugs

A U.S. Postal Service (USPS) Postmaster, who is also a service-connected Veteran, was indicted and arrested for mail theft. A VA OIG and USPS OIG investigation revealed that the defendant stole 50–60 VA narcotic parcels from a U.S. mail sorting facility.

Defendant Pleads Guilty to Possession of a Controlled Substance

A defendant pled guilty to possession of a controlled substance. An OIG investigation determined that the defendant, who resided in transitional housing for homeless Veterans, sold heroin to Veterans receiving treatment at the Lyons, NJ, VAMC where the transitional facility is co-located.

Mortgage Broker Sentenced for Fraud

A mortgage broker was sentenced to 4 months' incarceration, 6 months' home detention, 3 years' probation, and ordered to forfeit \$327,039 after pleading guilty to conspiracy to commit mail, wire, and bank fraud. An OIG and FBI investigation determined that the defendant provided funds to multiple buyers that were used as the down payment during real estate closings. The funds were fraudulently reported on the Uniform Residential Loan Application form as gifts from a family member and were used to increase the buyers' credit scores allowing them to qualify for larger mortgages. Thirteen loans were identified in the scheme, including a VA-guaranteed home loan. The potential loss to the VA should this guaranteed VA home loan default is approximately \$152,203.

Veteran Pleads Guilty to Theft of Government Funds

A Veteran pled guilty to the theft of Government funds. A VA OIG, IRS-CI, and Department of Labor OIG investigation revealed that the defendant, who was receiving VA Individual Unemployability (IU) compensation, reported to VA that he was not employed. The investigation further revealed that while collecting the IU benefits, the defendant was employed as a building contractor. The defendant reimbursed VA \$122,993, which is the amount of the stolen funds.

Non-Veteran Pleads Guilty to False Statements

A non-Veteran, who claimed to have served in Vietnam with the U.S. Marine Corps, pled guilty to false statements. An OIG investigation revealed that the defendant received VA health care and other benefits that he was not entitled to receive. The defendant was previously convicted in 2008 for defrauding VA of more than \$75,000 and was sentenced to 2 years' incarceration. The current loss to VA is \$31,696.

Non-Veteran Arrested for Making False Claims to the Government

A non-Veteran was arrested after being indicted for making false claims to the Government. An OIG and Defense Criminal Investigation Service determined that the defendant, who never served in the U.S. armed forces, received medical treatment at the Miami, FL, VAMC. The defendant unsuccessfully filed for disability compensation and pension benefits numerous times. The loss to VA is \$55,458.

Non-Veteran Arrested for Theft and False Statements

A non-Veteran was arrested after being indicted for theft of Government funds and false statements. A VA OIG and Department of Housing and Urban Development (HUD) OIG investigation determined that the defendant, who never served in the U.S. armed forces, received medical treatment at the Topeka, KS, VAMC and HUD-Veterans Affairs Supportive Housing benefits. The defendant also filed for VA disability compensation and pension benefits on multiple occasions, all of which were denied. The loss to VA is \$223,664 and the loss to HUD is \$5,131.

Son of Deceased VA Beneficiary Pleads Guilty to Theft

The son of a deceased VA beneficiary pled guilty to the fraudulent acceptance of VA benefits. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after his mother's death in August 2005. The loss to VA is \$92,152.

Daughter and Son of Deceased Beneficiary Arrested for Theft

The daughter and son of a deceased VA beneficiary were arrested for theft of VA benefits that were direct deposited after their mother's death in May 2008. The loss to VA is \$65,951.

VA Funds Recovered

An OIG investigation revealed that VA direct deposited compensation benefits into the bank account of a Veteran who died in March 1981. The bank eventually abandoned the funds to the Commonwealth of Virginia in October 2011. Working in conjunction with VA's Debt Management Center, OIG was able to recover \$684,384 from the Commonwealth of Virginia.

Eight Veterans Indicted for Travel Benefit Fraud

Eight Veterans were indicted for theft of public money. An OIG and VA Police Service investigation revealed that each of the defendants submitted fraudulent travel voucher claims to the Mountain Home, TN, VAMC. Each defendant claimed a false address which increased their distance of travel to and from the VAMC. The total loss to VA is \$40,188.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 4 months' home detention, 5 years' probation, and ordered to pay restitution of \$23,795. An OIG investigation revealed that from September 2008 to June 2013 the defendant submitted 740 fraudulent travel benefit vouchers claiming that he resided 40 miles from the Clarksburg, WV, VAMC. The defendant actually lived within 2–3 miles of the VAMC.

Fugitive Arrested With Assistance of OIG

A Veteran was arrested by the local sheriff's office with the assistance of OIG and the U.S. Marshals Service at the West Palm Beach, FL, VAMC. The defendant was wanted for violation of probation stemming from aggravated assault with a deadly weapon.



Richard J. Griffin
Acting Inspector General