OIG REPORTS
Inspector General Issues Final Report on Phoenix Health Care System Waiting List, Makes 24 Recommendations to VA Secretary for Corrective Action

This is the final report addressing allegations of gross mismanagement of VA resources, criminal misconduct by senior leadership, systemic patient safety issues, and possible wrongful deaths at the Phoenix VA Health Care System (HCS). The Office of Inspector General (OIG) found patients at the Phoenix VA HCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them. Patients frequently encountered obstacles when patients or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while traveling or temporarily living in Phoenix. In February 2014, a whistleblower alleged that 40 veterans died waiting for an appointment but the whistleblower did not provide OIG with a list of 40 patient names. However, OIG conducted a broader review of 3,409 veteran patients identified from multiple sources, including the electronic wait list, various paper wait lists, the OIG Hotline, the U.S. House Veterans’ Affairs Committee and other congressional sources, and media reports. OIG was unable to assert that the absence of timely quality care caused the deaths of these veterans.

This report includes case reviews of 45 patients who experienced unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care. The patients discussed reflect both patients who were negatively impacted by care delays (28 patients including 6 deaths), as well as patients whose care deviated from the expected standard independent of delays (17 patients including 14 deaths). In addition to 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the Phoenix VA HCS electronic wait list, OIG identified over 3,500 additional veterans. Many of the 3,500 veterans were on what OIG determined to be unofficial wait lists and were at risk of never obtaining their requested or necessary appointments.

Since the Phoenix VA HCS story first appeared in the national media, the OIG received approximately 225 allegations regarding health care at Phoenix and approximately 445 allegations regarding manipulated wait times at other VA medical facilities. OIG’s Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. OIG is coordinating investigations with the Department of Justice and the Federal Bureau of Investigation (FBI). These investigations, while most are still ongoing, have confirmed that wait time manipulations are prevalent throughout the Veterans Health Administration (VHA). VHA did not hold senior headquarters and facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures. In May 2013, the then Deputy Under Secretary for Health for Operations Management waived the Fiscal Year (FY) 2013 annual requirement for facility directors to certify compliance with the VHA.
scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. The use of inappropriate scheduling practices caused reported wait times to be unreliable. The systemic underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA’s senior leaders and mid-managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible. Where OIG confirmed potential criminal violations, OIG presented findings to the appropriate Federal prosecutors. If prosecution was declined, OIG provided documented results of investigation to VA’s senior management for appropriate administrative action. OIG will do the same when investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, OIG kept the U.S. Office of Special Counsel apprised of active criminal investigations as they relate to referrals of whistleblower disclosures of allegations relating to wait times and scheduling issues.

This report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a HCS that often could not timely respond to their mental and physical health needs. Immediate and substantive changes are needed. If headquarters and facility leadership are held accountable for fully implementing VA’s action plans for this report’s 24 recommendations, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide accelerated, timely access to the high quality health care veterans have earned—when and where they need it. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans. OIG will establish a rigorous follow-up to ensure full implementation of all corrective actions. The VA Secretary acknowledged that VA is in the midst of a very serious crisis and will use OIG’s recommendations to hone the focus of VA’s actions moving forward. The VA Secretary also apologized to all veterans and stated VA will continue to listen to veterans, their families, Veterans Service Organizations, and VA employees to improve access to the care and benefits veterans earned and deserve. [Click here to access report.]

IG Attributes 131 Days of Disability Claims Processing Time to Delay in Requesting and Receiving Department of Defense Treatment Records
This audit was congressionally required by the Consolidated Appropriations Act, 2014. The Act directed VA OIG, in coordination with the Department of Defense (DoD) OIG, to examine the processes and procedures for transmitting service treatment records (STRs) and personnel records from DoD to VA. OIG focused their efforts on the Veterans Benefits Administration’s (VBA) processes and timeliness of requesting paper STRs and providing them to VA Regional Office (VARO) staff that need the records to make decisions on veterans’ disability compensation claims. OIG also assessed initial timeliness of receiving electronic STRs from DoD, which is a process that began in January 2014. OIG determined that DoD is not timely in providing VBA electronic STRs. From January 1 through June 3, 2014, VBA submitted 7,278 STR requests to...
DoD for veterans who submitted claims and separated from military service on or after January 1, 2014. Of those, DoD only completed 2,111 requests (29 percent) and 5,167 requests (71 percent) were pending. Of the 2,111 completed STR requests, 377 requests (18 percent) were received by VBA within 45 calendar days of the veterans’ separation from military service. This occurred because DoD reported experiencing challenges and delays implementing the process of transmitting electronic STRs to VBA. Based on a review of 400 statistically selected original disability compensation claims completed during calendar year 2013, OIG identified delays within VBA’s processes. Delays occurred with VARO staff establishing claims, requesting STRs, and receiving requested STRs. Overall, OIG attributed a total of about 131 days to these actions. Delays occurred primarily because of VBA’s focus on eliminating the disability claims backlog. As a result of these delays, DoD and VBA need to improve timeliness of their current STR processes in order for VBA to achieve its timeliness goal of processing all claims within 125 days. OIG made recommendations to the Under Secretary for Benefits to improve VBA’s processes of requesting and providing STRs to VARO staff. The Under Secretary for Benefits concurred with OIG’s recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions. [Click here to access report.]

Dublin, Georgia, VAMC Closed Consult Requests for More than 600 Patients Without Being Seen by Provider
OIG conducted an inspection in response to a complaint, followed by a request from Congressman Jack Kingston, regarding alleged consult mismanagement at the Carl Vinson VAMC in Dublin, GA. OIG found that, in order to meet organizational goals, facility staff improperly “batch closed” more than 1,500 Non-VA Care Coordination (NVCC) consults on April 25, 2014. Batch closure should not have been used to close current requests for care. NVCC staff had generally been following established procedures to individually close older consults in the months preceding the batch closure. By batch closing 1,546 consults, the facility met the consult closure May 1 deadline. More than 600 patients whose consults were batch closed had not been seen by an NVCC provider at the time of consult closure. While OIG substantiated that NVCC staff were instructed to send NVCC consults back to the requesting providers for clinical review, and in some cases, providers had to re-enter consults, this action was appropriate and followed Consult Clean-Up guidance. As a result of the batch-closure, NVCC staff had to re-enter fee authorizations when care was still needed. The facility had difficulty scheduling timely non-VA care appointments. While they did not monitor timeliness of NVCC appointments, a VISN report showed that for the period October 1, 2013, though March 31, 2014, the facility failed to meet VHA’s 90-day goal each month. Because some NVCC providers are overwhelmed with referrals, patients requiring certain types of specialty care can wait months for appointments. OIG recommended that the VISN Director review the circumstances surrounding the batch closures and confer with appropriate VA offices to determine the need to take administrative action, if any, and that the Facility Director track the timeliness of NVCC appointment scheduling and promptly respond to potential delays. [Click here to access report.]
Recruitment Difficulties for Leadership and Clinical Positions Are Delaying Reopening of Fort Wayne, Indiana, Facility's Intensive Care Unit

OIG conducted an oversight review to follow up on the published report, *Healthcare Inspection - Review of Circumstances Leading to a Pause in Providing Inpatient Care at the VA Northern Indiana Healthcare System, Fort Wayne, Indiana, Report No. 13-00670-265*, issued on August 2, 2013. At the time of OIG’s follow-up review, 16 medical beds with telemetry capability on the acute medical unit were open; however, the Intensive Care Unit (ICU) remained closed. As a result, the facility did not accept medically complex patients and offered only limited surgical procedures. Consequently, many area veterans continue to receive Non-VA Care. Although VHA approved the facility’s proposal to reopen the ICU as a Level 4 ICU, an official date had not been established as of July 2, 2014. OIG found the facility has taken actions to actively recruit qualified clinical and leadership staff, but some clinical staff positions needed to be filled prior to the reopening of the ICU and some leadership positions remained vacant. OIG recommended the Veterans Integrated Service Network (VISN) Director ensure continued monitoring and implementation of actions for the reopening of the ICU. OIG recommended the VISN Director and the VA Northern Indiana Healthcare System (VANIHCS) Director ensure recruitment efforts continue for vacant leadership and clinical staff positions. OIG recommended the VANIHCS Director ensure that nursing leaders assess the utilization of the nursing staff to systemically plan assignments during times when the acute medical unit’s census is low.

[Click here to access report.]

Allegations of Poor Coordination and Care Not Substantiated at the VA Black Hills Health Care System, Fort Meade, South Dakota

OIG conducted a review in response to allegations received by Senator Tim Johnson’s office concerning poor coordination and delivery of care at the VA Black Hills HCS, Fort Meade, SD. OIG was unable to substantiate the allegation that the telephone contact and triage process in place during 2012 was cumbersome, resulted in delayed responses from primary care providers to patients calling for medical care or advice, or was set up to divert calls away from primary care providers. OIG did not substantiate the allegation that a veteran’s spouse received inaccurate information on obtaining emergency care outside of the system. The staff at the system followed the system policy when providing information on where to take the veteran for care. OIG did not substantiate the allegation of “negligence and medical errors” at the system during the veteran’s evaluation and subsequent admission in November 2012. Review of the electronic health records showed appropriate care of the veteran’s symptoms as they developed. OIG did not substantiate the allegation that VA did not make the veteran aware of all alternatives to care related to podiatry concerns. The veteran was seen by system podiatrists and treated appropriately. Referrals were made for non-VA care when indicated. OIG did not substantiate the allegation that a veteran’s spouse was denied care because of difficulty coordinating care under the Civilian Health and Medical Program of the VA(CHAMPVA). The spouse chose to use non-VA care when VA providers were available. VA does not fill prescription medications for CHAMPVA patients who receive care from non-VA providers. OIG made no recommendations.

[Click here to access report.]
OIG Makes Five Recommendations To Improve Caregiver Support Program at Charleston, South Carolina, VA Medical Center

OIG conducted an evaluation in response to allegations that the Caregiver Support Program (CSP) at the Ralph H. Johnson VA Medical Center (VAMC), Charleston, SC does not operate in accordance with Public Law 111-163 or VA guidelines. OIG found that: an interdisciplinary team had not appropriately assessed many veterans during the application process; facility leadership did not designate an interdisciplinary CSP team or develop a comprehensive assessment process until February 2014; more than 100 applications were awaiting initial CSP screening, and many of them exceeded the 45-day processing requirement; and CSP staff had not conducted 90-day and annual follow-up visits as required. OIG confirmed that the Chief of Social Work Service and facility leadership did not assure sufficient staffing in a timely manner to conduct CSP follow-up visits. OIG did not substantiate that the Caregiver Support Coordinator, who is a registered nurse, did not possess the knowledge, skills, and abilities to perform the job. OIG found that caregivers received stipend dollars even though the facility had not documented required annual reassessment. OIG made five recommendations. [Click here to access report.]

Results for Benefits Inspection of VARO, Des Moines, Iowa

OIG evaluated the Des Moines, IA, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 13 (23 percent) of 57 disability claims reviewed. OIG sampled claims OIG considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 7 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, primarily because management did not prioritize processing claims requiring reduced evaluations. Generally, VARO staff demonstrated experience and knowledge in correctly processing complex traumatic brain injury (TBI) claims. VARO staff incorrectly processed three of nine special monthly compensation (SMC) and ancillary benefits claims because specialized staff did not complete these claims as required and the VARO had no second level review policy. Management generally ensured Systematic Analyses of Operations (SAOs) were complete and timely. However, VARO staff did not timely or accurately complete 20 of 30 proposed benefits reduction cases due to VBA addressing other higher workload priorities. OIG recommended the VARO Director review the 131 temporary 100 percent disability evaluations remaining from their inspection universe and take appropriate action. The Director should establish a second-level review policy and ensure specialized staff process complex SMC claims. The Director also should develop and implement a plan to ensure staff timely process benefits reductions. The Director of the Des Moines, IA, VARO concurred with all recommendations. OIG will follow up on these actions as deemed necessary. [Click here to access report.]

Results for Benefits Inspection of VARO Columbia, South Carolina

OIG evaluated the Columbia, SC, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 36 (40 percent) of 89 disability claims reviewed. OIG sampled claims considered to be at a higher risk of processing errors, thus these results do not represent this VARO’s overall disability claims...
processing accuracy rate. Specifically, 22 of 29 temporary 100 percent disability evaluations reviewed were inaccurate, generally because staff did not timely process reminder notifications for medical reexaminations. Staff incorrectly processed 10 of 30 TBI claims, primarily by using insufficient medical examination reports. VARO staff also incorrectly processed 4 of 30 special monthly SMC claims due to a lack of training. Three of 11 SAOs were incomplete because management did not provide adequate training to ensure staff completed the SAOs correctly. VARO staff did not timely or accurately complete 18 of 30 proposed benefits reduction cases because management did not prioritize this work. Further, Veterans Service Center management considered benefit reduction delays procedural deficiencies, not errors. Management stated the delays occurred because VBA leadership directed the VARO to focus on other national priorities. Moreover, management indicated it had the discretion to grant staff extensions to complete this work, though OIG found the extensions unmerited given the financial risks associated with potential overpayments. OIG recommended the Columbia, SC, VARO Director implement a plan to ensure staff take timely action on reminder notifications and take appropriate action on the 658 temporary 100 percent disability evaluations remaining from their inspection universe. The Director also should ensure staff receives training on properly completing TBI claims, SMC benefits, and SAOs, and implement a plan to ensure prompt action on rating reductions. The Director concurred with all recommendations. OIG will follow up as deemed appropriate on these actions. [Click here to access report.]

Benefits Inspection Results for VARO, Atlanta, Georgia
OIG evaluated the Atlanta, GA, VARO to see how well it accomplishes its mission. OIG also assessed the merits of a complaint involving deceptive VARO mail management practices. OIG found VARO staff did not accurately process 34 (38 percent) of 90 disability claims reviewed. OIG sampled claims considered to be at a higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits. Seventeen of 30 temporary 100 percent disability evaluations reviewed were inaccurate. Generally, the errors occurred because VARO staff did not take timely action on reminder notifications for medical reexaminations. VARO staff incorrectly processed 8 of 30 TBI claims because oversight was lacking to ensure staff complied with VBA’s second-signature policy. Further, staff incorrectly processed 9 of 30 special monthly compensation and ancillary benefits claims due to a lack of training. VARO managers ensured SAOs were complete, timely, and contained the analysis and recommendations needed to address deficiencies. However, VARO staff delayed completing 16 of 30 benefit reduction cases because management assigned staff to address other priorities. OIG did not substantiate anonymous allegations concerning deceptive mail management practices at the Atlanta, GA, VARO. OIG recommended the VARO Director develop and implement a plan to ensure staff take timely action on reminder notifications for medical reexaminations; review and take appropriate action on the 776 temporary 100 percent disability evaluations remaining from their inspection universe; ensure effective second-signature reviews and training on processing TBI, special monthly compensation, and ancillary benefits claims; and
develop a plan to prioritize actions on benefit reduction cases. The VARO Director concurred with all recommendations and the planned corrective actions are responsive. OIG will follow up on these actions as deemed appropriate.

[Click here to access report.]

**Combined Assessment Program Reviews**

In August 2014, OIG published seven Combined Assessment Program (CAP) reviews containing findings for the medical centers and HCSs 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) acute ischemic stroke care, (6) community living center resident independence and dignity, and (7) magnetic resonance imaging safety.

**VA Bay Pines HCS, Bay Pines, Florida**  
**Fayetteville VAMC, Fayetteville, North Carolina**  
**VA New York Harbor HCS, New York, New York**  
**Clement J. Zablocki VAMC, Milwaukee, Wisconsin**  
**James J. Peters VAMC, Bronx, New York**  
**Washington DC VAMC, Washington, District of Columbia**  

**Community Based Outpatient Clinic Reviews**

In August 2014, OIG published six Community Based Outpatient Clinic (CBOC) reviews containing 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.

**Fayetteville VA Medical Center, Fayetteville, North Carolina**  
**Providence VAMC, Providence, Rhode Island**  
**Clement J. Zablocki VAMC, Milwaukee, Wisconsin**  
**VA Bay Pines HCS, Bay Pines, Florida**  
**VA New York Harbor HCS, New York, New York**  
**VA New Mexico HCS, Albuquerque, New Mexico**

**CRIMINAL INVESTIGATIONS**

**Former State of Maryland, Department of Veterans Affairs, Employee Pleads Guilty to Extortion**

A former Maryland VA employee pled guilty to extortion. An OIG investigation revealed that from 2003 to 2011, while working at the Maryland VA, the defendant created fraudulent doctor notes and amendment forms commonly referred to as DD-215s as part of claims for service-connected disabilities. The defendant solicited and received cash payments from veterans in exchange for assistance with their claims. The doctor's
notes claimed that the veterans had been diagnosed with diabetes and were insulin dependent. The fraudulent DD-215s were used as proof of service in Vietnam. The defendant also filed a fraudulent DD-215 form to increase his own rating for post-traumatic stress disorder. A total of 17 veterans received compensation benefits using the fraudulent forms. The loss to VA is $1,151,219. The State employee also assisted the veterans in receiving $255,555 in property tax waivers from the State that they were not entitled to receive.

**Former Contract Employee Arrested for Identity Theft**
A former employee of a company contracted by the Tampa, FL, VAMC to shred sensitive documents was indicted and arrested for unlawful disclosure of protected health information, access device fraud, and aggravated identity theft. An OIG, Internal Revenue Service Criminal Investigation (IRS-CI), Florida Department of Law Enforcement, Florida Highway Patrol, local Sheriff’s office, and local police department investigation revealed that the defendant stole medical records containing veterans’ personally identifiable information (PII) that were intended to be destroyed. The defendant then sold the records to multiple defendants who subsequently used the PII to file $1.4 million in fraudulent tax returns. One of these defendants, who bought the PII, was sentenced to 54 months’ incarceration, 36 months’ supervised release, and ordered to pay $295,000 in restitution. This defendant subsequently used the stolen PII to file $418,723 in fraudulent tax returns.

**Veteran Involuntarily Committed for Making Threats to Sacramento, California, VAMC**
A veteran was placed on a 72-hour involuntary psychiatric hold after making multiple telephonic bomb threats against the Sacramento, CA, VAMC. An OIG investigation revealed that in addition to the recent threat made by the veteran he had made similar threats in the past that resulted in bomb searches and evacuations of the medical center.

**San Francisco, California, VAMC Food Service Worker Sentenced for Making Threats**
A San Francisco, CA, VAMC Food Service worker was sentenced to 50 hours’ community service after pleading guilty to impeding or disrupting the performance of official duties of Government employees. An OIG and VA Police Service investigation revealed that the defendant placed a suspicious package wrapped in a black trash bag in the food service area of the medical center. A note was attached to the package that warned of “severe eye damage and possible blindness for the rest of your natural life,” if the package was opened.

**Former Gainesville, Florida, VAMC Employee Sentenced for Identity Theft**
A former Gainesville, FL, VAMC medical support assistant was sentenced to 2 years’ probation after pleading guilty to attempting to use the identity of another person. An OIG, IRS-CI, and local police investigation revealed that the defendant unlawfully obtained veterans’ PII with the intent of filing false tax returns.
Former Tampa, Florida, VAMC Volunteer Sentenced for Identity Theft
A former Tampa, FL, VAMC volunteer was sentenced to 48 months’ incarceration and 36 months’ supervised release. A non-veteran was sentenced to 42 months’ incarceration, 36 months’ supervised release, and ordered to pay $149,864 in restitution. An OIG and IRS-CI investigation revealed that the former volunteer stole VAMC patients’ PII and sold or traded it to his co-defendant for crack cocaine, knowing that the PII would be used to file fraudulent tax returns. The stolen PII was subsequently used to file $552,981 in fraudulent returns.

Non-Veteran Arrested for Mail Fraud and Identity Theft
A non-veteran was arrested for mail fraud and aggravated identity theft. 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. The defendant’s non-veteran husband was previously indicted and arrested in this case.

Fresno, California, VAMC Community Living Center Nurse Charged with Elder Abuse
A Fresno, CA, VAMC Community Living Center (CLC) nurse was charged with elder abuse. An OIG investigation revealed that the nurse entered the veteran’s CLC room and requested the veteran get out of bed. When the veteran ignored the request the defendant grabbed the veteran by his ear, pulled him out of bed, and forced him into a wheelchair. This action resulted in a serious laceration to the veteran’s left ear.

Tallahassee, Florida, VA Outpatient Clinic Dental Technician Sentenced for Practicing Dentistry Without a License
A Tallahassee, FL, VA outpatient clinic dental technician was sentenced to 24 months’ incarceration, 156 months’ probation, and 650 hours’ community service after being convicted at trial of practicing dentistry without a license. An OIG and local sheriff’s office investigation determined that the defendant identified victims through her employment as a VA dental technician and then used stolen VA equipment to perform dental surgery.

Former VA Fiduciary Pled Guilty to Misappropriation
A former VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation determined that the fiduciary misused $28,305 in VA funds that should have been used to pay the veteran’s nursing home expenses. The defendant used the stolen funds to support a failed construction business.

VA Fiduciary Pled Guilty to Misappropriation
A VA fiduciary pled guilty to misappropriation by a fiduciary. During an OIG investigation, the defendant admitted to stealing at least $120,000 from veterans and non-Federal state conservatorship accounts that had been placed under his control.
Former VA Fiduciary Sentenced for Theft
A former VA fiduciary and city prosecutor was sentenced to 24 months’ incarceration, 3 years’ supervised release, and ordered to pay restitution of $198,669 after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant, appointed fiduciary for five incompetent veterans, embezzled VA benefits from the veterans and used the funds for personal expenses. The defendant is also facing additional State charges.

Fiduciary Sentenced for Theft
The brother of a VA beneficiary, who was also his fiduciary, was sentenced to 3 years’ probation, 25 hours’ community service, and ordered to pay VA restitution of $102,726 after pleading guilty to theft by unlawful taking. An OIG and local police investigation revealed that the defendant submitted an accounting to VA that falsely identified expenses pertaining to his brother for entertainment, clothing, and room and board. During this time period, the veteran was a bedridden inpatient at a VAMC. When interviewed, the defendant admitted to embezzling his brother’s VA benefits and using the funds to buy a car and for travel expenses.

Fiduciary Arrested for Theft
The son of a VA beneficiary, who was also his fiduciary, was arrested for theft by unlawful taking and wire fraud. A VA OIG, Social Security Administration (SSA) OIG, and Health and Human Services OIG investigation revealed that the defendant had been embezzling his father’s VA, SSA, and personal funds since 2010. The loss is approximately $70,000.

Former Jackson, Mississippi, VAMC X-Ray Technician Sentenced for Theft
A former Jackson, MS, VAMC x-ray technician was sentenced to 3 years’ supervised probation, $750 in fines and fees, and ordered to complete a drug and alcohol treatment program after pleading guilty to grand larceny. An OIG investigation revealed that the defendant stole a VA laptop from the medical center and kept it for personal use. The laptop was recovered and contained no PII.

Veterans Charged with Travel Benefit Fraud at the Asheville, NC, VAMC
A proactive investigation into the beneficiary travel program at the Asheville, NC, VAMC resulted in charges being filed against eight veterans for false, fictitious, or fraudulent claims. A total of 12 veterans were the subjects of this investigation; the remaining four are currently in plea negotiations with the U.S. Attorney’s Office. The approximate aggregate loss to VA is $100,000.

Veteran Sentenced for Travel Benefit Fraud
A veteran was sentenced to 5 years’ probation, 6 months' home confinement, 20 hours’ community service, attend counseling, and ordered to pay $42,749 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant filed over 600 fraudulent travel vouchers with the Tuscaloosa, AL, VAMC.
Veteran’s Son Arrested for Exploitation
The son of a veteran was indicted and arrested for exploitation of an aged adult and theft from a person 65 years of age or older. An OIG and local sheriff’s office investigation revealed that the defendant abandoned the veteran at a residence, stole the veteran’s debit card, and continued to use VA benefits intended for the veteran. The loss is $31,353.

Veteran Sentenced for VA Compensation Fraud
A veteran was sentenced to 60 months’ probation and ordered to pay VA $26,989 in restitution. An OIG investigation revealed that between February 2006 and October 2007 the defendant concealed his employment from VA in order to continue to receive individual unemployability benefits.

Son of a Deceased VA Beneficiary Sentenced for Theft
The son of a deceased beneficiary was sentenced to 3 years’ probation and ordered to pay VA $92,152 in restitution. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited to his mother’s account after her death in August 2005.

Son of Deceased Beneficiary Sentenced for Theft of VA Benefits
The son of a deceased beneficiary was sentenced to 30 days’ incarceration, 60 months’ probation, and ordered to pay restitution of $86,802. An OIG and FBI determined that the defendant stole VA benefits that were direct deposited after the veteran’s death in December 2010.

Veteran Sentenced for “Doctor Shopping” for Controlled Substances
A veteran was sentenced to 11 months and 29 days’ incarceration (suspended) and 11 months and 29 days’ probation after pleading guilty to failing to disclose to a health care practitioner the receipt of a controlled substance of similar therapeutic use within the previous 30 days. An OIG investigation revealed that the defendant obtained controlled substances from both VA and non-VA providers during the same time period. The defendant’s ability to receive controlled substances from VA has been terminated.

Former U.S. Postal Service Employee Pleads Guilty to Theft
A former U.S. Postal Service (USPS) employee pled guilty to delay of mail, theft of mail by a postal employee, and conspiracy to distribute a controlled substance. A VA OIG and USPS OIG investigation determined that from 2010 to 2013 the defendant stole VA packages containing narcotic drugs from a USPS distribution facility. The defendant admitted to selling the stolen narcotics. A Federal search warrant executed at the defendant’s residence revealed large quantities of stolen narcotics as well as stolen mail matter.

Former United Parcel Service Employee Arrested for Drug Possession
A former United Parcel Service (UPS) employee was indicted and arrested for possession of a controlled substance with intent to sell or deliver and obtaining a controlled substance by fraud. An OIG investigation revealed that the defendant stole
1,520 tablets of VA controlled substances from 8 UPS packages. Further investigation revealed that the defendant then personally used and sold some of the controlled substances.

Richard J. Griffin
Acting Inspector General