



# Department of Veterans Affairs

## Office of Inspector General

### September 2014 Highlights

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#### **CONGRESSIONAL TESTIMONY**

##### **Acting Inspector General Testifies Before Senate Panel on Office of Inspector General Findings and Recommendations on Patient Deaths and Scheduling Delays at Phoenix Health Care System**

Richard J. Griffin, Acting Inspector General, testified before the Committee on Veterans' Affairs, United States Senate, on the "State of VA Healthcare." He discussed the Office of Inspector General's (OIG) recent report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*.

Mr. Griffin discussed the findings and the 24 recommendations in the report as well as the scope and methodology used by the OIG to determine if veterans died while waiting for appointments at the Phoenix VA Health Care System. He was accompanied by Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections; Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General, and Mr. Larry Reinkemeyer, Director, OIG Kansas City Office of Audits and Evaluations. [\[Click here to access testimony.\]](#)

##### **Acting Inspector General Vigorously Rejects Speculation That VA Influenced Phoenix Report Findings at U.S. House Committee on Veterans' Affairs**

Richard J. Griffin, Acting Inspector General, testified before the Committee on Veterans' Affairs, United States House of Representatives, at a hearing on "Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report."

Mr. Griffin refuted allegations that the OIG's report findings were changed by VA during the draft report review and comment process, in particular, the insertion of a sentence that the OIG could not conclusively assert that the absence of timely care caused the deaths of these veterans. He explained that this sentence was inserted for clarity to summarize the results of the OIG's clinical case reviews that were performed by our board-certified physicians, and that the change was made strictly on the OIG's own initiative; neither the language nor the concept was suggested by anyone at VA. He was accompanied by Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections; Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General, and Mr. Larry Reinkemeyer, Director, OIG Kansas City Office of Audits and Evaluations.

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

#### **ADMINISTRATIVE INVESTIGATIONS**

##### **Senior VA Procurement Official Pressured Contracting Staff To Give Preference in Reverse Auction Services Task Order**

The Veterans Health Administration (VHA) Deputy Chief Procurement Officer engaged in conduct prejudicial to the Government, a conflict of interest, improperly disclosed non-public VA information, misused her position and VA resources, engaged in a prohibited personnel practice, interfered with a OIG contract review, acted as an agent

of FedBid, Inc. in matters before the Government, and did not testify freely and honestly. Additionally, in order to financially benefit FedBid, Inc., the employee, along with a close friend and FedBid, Inc. executives, willfully and improperly acted to thwart a VA official in his oversight duties associated with VA's procurement operations. Together they took significant measures to disrupt and deprive VA's right to transact official business honestly and impartially, free from improper and undue influence. [\[Click here to access report.\]](#)

## **OIG REPORTS**

### **Review of Fed Bid Contract Finds Reported Savings Overrated and Negative Impact on Federal Supply Schedule Contractors**

OIG conducted a review of VHA's use of commercial reverse auctions to procure products and services. The review determined that the methodology used to calculate and report savings by using reverse auctions greatly overstated any actual savings and did not comply with VHA's standard operating procedure. VHA's mandatory requirement to use reverse auctions violated VA's policy for using priority sources such as Federal Supply Schedule (FSS) contracts. Over 93 percent of the contract files reviewed did not contain proper documentation to validate the use of reverse auctions in accordance with VHA's standard operating procedure. The review also determined that contracting officials run the risk of purchasing gray market items by using reverse auctions. [\[Click here to access report.\]](#)

### **Anonymous Allegations That Los Angeles, California, VA Regional Office Management Manipulated Data Not Substantiated**

On June 24, 2014, OIG received an anonymous allegation that Los Angeles, CA, VA Regional Office (VARO) management instructed staff to manipulate data to meet a Veterans Benefits Administration (VBA) claims processing timeliness goal. The complainant alleged that management told staff to update VBA's electronic system to make it appear that VARO staff properly requested documentation to support veterans' claims, although no actions were actually taken to obtain the required evidence. OIG did not substantiate the allegation that management instructed staff to input incorrect data in VBA's electronic system. OIG determined VARO management provided written instructions to the assigned veterans service representatives on initiating development of evidence to process 183 claims. However, OIG found that one of the seven veterans service representatives assigned this workload had made entries in VBA's electronic system to reflect documentation had been requested to support veterans' claims, although the employee took no actions to obtain the required evidence. This veterans service representative acknowledged manipulating data for claims, stating this was done to comply with verbal instructions from management. Based on the review, OIG concluded one employee misunderstood management's instructions and made improper entries in VBA's electronic system. Since the errors were the result of one individual, OIG did not consider this a systemic issue. However, given the nature and seriousness of the employee's claims processing errors, OIG recommended that the VARO Director take action to correct the fourteen errors the employee introduced in the electronic records on the claims processed. OIG also recommended the Director

ensure monitoring of all employees' work to ensure that all future work is performed in accordance with VBA policy. [\[Click here to access report.\]](#)

### **Inappropriate Actions Misstated Houston, Texas, VARO's Inventory, Timeliness, and Placed Some Claims at Risk of No Decision**

On July 10, 2014, the OIG received an allegation from VBA senior leadership in VA Central Office that a Houston VARO employee inappropriately changed or removed system controls for benefits claims without taking proper actions on the claims. VBA uses electronic system controls to identify types of claims, and manage and measure its pending and completed workloads. Generally, such controls should remain in place until all required actions are completed on claims, including providing notices of benefits decisions to the claimants. OIG substantiated the allegation that the employee inappropriately cleared, changed, and cancelled controls in the electronic record used to track and identify benefits claims without taking proper actions to complete the claims. The VARO's independent review team determined the employee incorrectly cleared system controls in 136 (44 percent) of 308 claims, making these unfinished claims appear to be completed. OIG sampled 60 of the 308 cases and determined the independent review team accurately identified whether corrective actions were needed and established new controls where required. Further, OIG found the employee incorrectly changed or cancelled system controls in 38 of 51 additional claims OIG sampled. The employee believed the actions were appropriate and would improve production, but conceded making mistakes during what he said was a period of immense stress. To address the issue, VBA leadership initiated administrative action, to include removal of the employee's system access. These inappropriate actions misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may never have received decisions on their claims if the VARO's independent review team had not discovered the improper actions by the employee. OIG's review did not identify any fraud resulting in personal financial gain; however, the inappropriate actions described in this report undermine program effectiveness. Therefore, OIG recommended the Houston VARO Director take immediate action to fully review and correct, as appropriate, all actions the employee took to clear, change, or cancel controls for claims. OIG also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee. [\[Click here to access report.\]](#)

### **Emergency Airway Management Policies, Training, and Competency Assessments Need Improvement at Salisbury, North Carolina, VA Medical Center**

OIG conducted an inspection in response to allegations regarding out of operating room airway management (OOORAM) at the W. G. (Bill) Hefner VA Medical Center (VAMC) in Salisbury, NC. OIG substantiated that the facility's local policy for OOORAM was not updated as required and, when a new policy was implemented, it did not contain all the components required by Veterans Health Administration (VHA) Directive 2012-032. OIG also substantiated that the facility's OOORAM training and competency assessments were not consistently completed as required, not enough staff were authorized to perform OOORAM and some staff performed OOORAM without

authorization, highly portable video laryngoscopes were not always immediately available, and required analysis after patient care events involving intubation by unauthorized facility staff did not always occur. OIG did not substantiate there was an unacceptable number of “Code Blues” (an emergency situation announced in a hospital to indicate a patient requires immediate resuscitation) and found the facility reviewed events where cardiopulmonary resuscitation was attempted as required. During the course of this review, OIG found the facility had not updated the scope of practice for a non-licensed independent practitioner who was authorized to perform OORAM. OIG recommended that the Facility Director ensure the facility’s OORAM policy is updated to include all VHA requirements, that processes be strengthened to complete OORAM training and competency requirements as outlined by VHA and local policies, that processes be strengthened to provide OORAM coverage as required, that highly portable video laryngoscope equipment is immediately available, that an analysis is performed for the five identified patient care events in our report, and that the scope of practices are updated for non-licensed independent practitioners who perform OORAM. [\[Click here to access report.\]](#)

### **OIG Recommends the Establishment of Consistent Processes for Notifying Patients and Providers of Cervical Cancer Screening Results**

The purpose of OIG’s systematic review of VHA’s Community Based Outpatient Clinics (CBOCs) was to evaluate compliance with selected VHA requirements regarding cervical cancer screenings and results reporting. The review focused on (1) whether women veterans, ages 23–64, received cervical cancer screening and (2) whether ordering providers and patients received notification of cervical cancer screening results within the timeframes established by VHA policy. OIG recommended that consistent processes be established for notifying (1) ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record and (2) women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record. [\[Click here to access report.\]](#)

### **OIG Identifies Need for Emergency Department Staffing Augmentation Plan at VA San Diego Healthcare System, San Diego, California**

OIG conducted an inspection in response to allegations concerning critically low registered nurse (RN) staffing levels and patient safety issues in the Emergency Department (ED) at the VA San Diego Healthcare System (HCS), San Diego, CA. OIG substantiated that three RNs were on shift after midnight. In June 2013, the ED included an additional full-time RN on the midnight shift to cover for RN call-ins. OIG substantiated the allegation that the HCS did not have an emergency plan or policy that addressed low RN staffing levels in the ED. However, VHA does not require a HCS policy that specifically addresses low RN staffing levels in the ED, but does require that facilities have a plan for additional RNs, providers, and support staff in times of acute overload or disaster. The ED did not have a plan for additional staff in times of acute overload or disaster. OIG did not substantiate that RNs who floated to the ED were not oriented to the floor. However, some RNs reported inadequate orientation at the time of the float. OIG did not substantiate that numerous Patient Event Reports were submitted

regarding critically low RN staffing levels on the night shift but no action had been taken. Six Patient Event Reports were submitted and reviewed, and appropriate follow-up actions were taken.

OIG partially substantiated the allegation that two patients waited over 9 hours for emergency care. ED staff completed intake assessments within a reasonable time period based on the patients' medical conditions. OIG recommended that the HCS Director implement a policy that includes an ED augmentation plan for additional RNs, providers, and support staff in times of acute overload or disaster and review orientation processes for RNs floating to the ED. [\[Click here to access report.\]](#)

### **Inspection of VARO White River Junction, Vermont**

OIG evaluated the White River Junction, VT, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 11 (22 percent) of 49 disability claims reviewed. OIG sampled claims we considered at higher risk of processing errors, thus these results do not represent this VARO's overall disability claims processing accuracy rate. Specifically, 6 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, generally because management did not ensure timely processing of temporary 100 percent cases requiring reduced evaluations and medical reexaminations. VARO staff incorrectly processed 1 of 10 traumatic brain injury claims. Staff also incorrectly processed 4 of 9 special monthly compensation (SMC) claims due to a lack of training and an ineffective second-level review process. All 11 Systematic Analyses of Operations (SAOs) were either incomplete or not submitted because of a lack of management oversight to ensure staff completed the SAOs correctly. VARO staff did not timely or accurately complete 6 of 27 proposed benefits reduction cases because management did not prioritize this workload. OIG recommended the VARO Director implement a plan to ensure staff timely process temporary 100 percent disability evaluations and review 33 such cases remaining from the inspection universe. The Director should provide refresher training and strengthen the additional level of review for SMC cases, ensure SAOs are complete, and implement a plan to ensure management oversight and processing of benefits reduction cases. The VARO Director concurred with all recommendations.

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

### **Inspection of VARO Chicago, Illinois**

OIG evaluated the Chicago, IL, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 35 (39 percent) of 89 disability claims reviewed. OIG sampled claims we considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 19 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, primarily because management did not prioritize processing of claims requiring reexaminations. VARO staff demonstrated experience and knowledge in correctly processing complex traumatic brain injury claims. VARO staff incorrectly processed 16 of 31 SMC and ancillary benefits claims due to a lack of recent effective training. Management did not complete 5 of 11 SAOs due to inadequate

oversight. VARO staff also did not timely complete 15 of 30 benefit reduction cases due to addressing other higher workload priorities.

OIG recommended the Chicago VARO Director review the 581 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action, as well as provide oversight to ensure staff follows VBA guidance for establishing suspense diaries and processing reminder notifications. The Director should ensure staff receive refresher training on proper processing of SMC and ancillary benefits and implement a plan to ensure effectiveness of the training. The Director should develop and implement a plan to ensure completion of all SAOs. Finally, the Director should amend, implement, and monitor the Workload Management Plan to ensure staff take timely action on processing proposed benefits reductions. The VARO Director concurred with all recommendations. [\[Click here to access report.\]](#)

### **Inspection of VARO Seattle, Washington**

OIG evaluated the Seattle, WA, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 22 (24 percent) of 90 disability claims reviewed. OIG sampled claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 15 of 30 temporary 100 percent disability evaluations reviewed were inaccurate. Errors related to temporary 100 percent disability evaluations primarily occurred because staff did not timely process reminder notifications for medical reexaminations. Generally, VARO staff accurately processed traumatic brain injury claims. However, VARO staff incorrectly processed 6 of 30 SMC and ancillary benefits claims due to lack of oversight and training. VARO managers ensured SAOs were complete and timely and contained the analyses and recommendations needed to address deficiencies. However, because VARO management required staff to address other work considered to be a higher priority, they delayed completing 11 of 30 benefits reduction cases. Taking timely and appropriate actions on benefits reductions is necessary to ensure financial stewardship and minimize improper benefits payments. OIG recommended the VARO Director develop and implement plans to ensure staff take timely action on reminder notifications for medical reexaminations; review and take appropriate action on the 576 temporary 100 percent disability evaluations remaining from OIG's inspection universe; ensure effective training and modify the local secondary review policy for processing SMC and ancillary benefits; and develop a plan to prioritize actions on benefits reduction cases. The VARO Director concurred with all recommendations. OIG will follow up on actions as deemed necessary. [\[Click here to access report.\]](#)

### **Combined Assessment Program Reviews**

In September 2014, OIG published five Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. 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 activities covered in each review are listed below.

**[Grand Junction VAMC, Grand Junction, Colorado](#)**

This review covered the following eight activities: (1) quality management (QM), (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, (7) magnetic resonance imaging safety, and (8) follow-up on colorectal cancer (CRC) screening.

**[John D. Dingell VAMC, Detroit, Michigan](#)**

This review covered the following seven activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, (6) community living center resident independence and dignity, and (7) magnetic resonance imaging safety.

**[Bath VAMC, Bath, New York](#)**

This review covered the following seven activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, (6) community living center resident independence and dignity, and (7) Mental Health Residential Rehabilitation Treatment Program.

**[VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon](#)**

This review covered the following eight activities: (1) QM, (2) EOC, (3) MM – controlled substance inspection program, (4) continuity of care, (5) management of test results, (6) suicide prevention program, (7) management of workplace violence, and (8) Mental Health Residential Rehabilitation Treatment Program.

**[Providence VAMC, Providence, Rhode Island](#)**

This review covered the following six activities: (1) QM, (2) EOC, (3) MM, (4) coordination of care, (5) acute ischemic stroke care, and (6) magnetic resonance imaging safety.

**CBOC Reviews**

In September 2014, OIG published five 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.

**[VA Long Beach HCS, Long Beach, California](#)**

**[Alexandria VA HCS, Pineville, Louisiana](#)**

**[Minneapolis VA HCS, Minneapolis, Minnesota](#)**

**[Bath VAMC, Bath, New York](#)**

**[Tennessee Valley HCS, Nashville, Tennessee](#)**

## **CRIMINAL INVESTIGATIONS**

### **Veteran Who Was Employed by the U.S. Department of Defense in Germany Admits To Fraudulently Receiving \$1.2M in VA Health Coverage**

A veteran living in Germany pled guilty to health care fraud after being extradited to the United States. The defendant agreed to a forfeiture judgment of \$2,205,032 with VA receiving \$1,261,512. A VA OIG, Office of Personnel Management OIG, U.S. Army Criminal Investigation Command, and Defense Criminal Investigative Service investigation revealed that the veteran falsified claims paid by the VA Foreign Medical Program and the Federal Employee's Health Benefit Program. The defendant was a civilian employee of the Department of Defense.

### **VA OIG, U.S. Postal Inspections Arrest Two Bronx, New York, VA Workers for Allegedly Distributing 5 Kilograms of Cocaine**

Two Bronx, NY, VAMC employees were arrested for possession with intent to distribute a controlled substance based on a complaint alleging that they engaged in a conspiracy to distribute more than 5 kilograms of cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and Drug Enforcement Administration (DEA) Organized Crime Drug Enforcement Strike Force investigation revealed that six U.S. Postal Service Priority Mail parcels containing 1–2 kilograms of cocaine were mailed from Puerto Rico to the VAMC warehouse. The defendants subsequently took possession of these packages and ultimately transferred the drugs off station. On the day of the arrest, agents observed the defendants take the package into a private office in the warehouse and exchange money for the package.

### **Veteran Pleads Guilty to Theft of Government Funds**

A veteran pled guilty to theft of Government funds. As part of the plea agreement, the defendant agreed to a forfeiture money judgment of \$503,298. An OIG investigation revealed that the defendant submitted altered DD-214s, a fraudulent Purple Heart certificate, and a forged "buddy statement" to VA in order to support his claim for post-traumatic stress disorder. The investigation also revealed that the defendant was "doctor shopping" from approximately January 2010 to August 2012.

### **Former VA Police Officer Sentenced for Attempted Robbery**

A former VA police officer was sentenced to 44 months' incarceration and 3 years' supervised release. An OIG investigation revealed that while working on duty at the Salisbury, NC, VAMC the officer attempted to rob the credit union, located on the campus of the VAMC, by forcing an employee into the credit union as she was opening for the day. The officer concealed his identify by wearing coveralls over his uniform, a ski mask, and gloves. Two construction workers witnessed the incident and chased the defendant as he fled from the scene. The officer evaded the workers by hiding in a heating, ventilating, and air conditioning room; exiting in his uniform; and assisting in the search for the "suspect." Later that day, a duffel bag containing the items worn during the attempted robbery was located in the locked heating, ventilating, and air conditioning room, and the officer was subsequently identified when he returned a few days later to retrieve the bag.

**Seven Veterans Arrested for False Statements**

Seven veterans were arrested for false statements related to the VA beneficiary travel program. An OIG investigation revealed that the defendants submitted false travel vouchers to the West Palm Beach, FL, VAMC in order to receive increased reimbursement for travel to and from their VA appointments. The loss to VA is approximately \$157,753.

**Omaha Contractor Faces Prison for Pass-Through Scheme That Took 45 Contracts Away From Veteran-Owned Businesses**

A VA contractor pled guilty to major program fraud. In addition, the defendant's company pled guilty to money laundering in furtherance of a fraudulent pass-through scheme. The guilty pleas follow a Service-Disabled Veteran-Owned Small Business's (SDVOSB) plea to major program fraud and wire fraud, which was entered on behalf of the SDVOSB by the service-disabled veteran owner. An indictment charged the contractor and service-disabled veteran owner in connection with a \$23.5 million SDVOSB fraud scheme. The charges included major fraud, wire fraud, money laundering, and conspiracy. Additionally, approximately \$3.9 million was seized as part of the investigation. An OIG investigation revealed that from approximately May 2007 to August 2010, the SDVOSB unlawfully received 45 set-aside and/or sole-source SDVOSB contracts from VA and the Department of Defense, to include contracts involving *American Recovery and Reinvestment Act of 2009* funds. The investigation further revealed that the SDVOSB was a pass-through and/or front company for the contractor's other businesses and that the service-disabled veteran was simply a figurehead or "rent-a-vet" who was being used for his service-disabled veteran status.

**Tennessee Grand Jury Returns Fraud Indictment in Scheme to Get Set-Aside Contracts Meant for Veterans and Small Business**

A veteran and three other defendants were indicted for major fraud against the U.S. Government, wire fraud, and conspiracy to commit wire fraud. A VA OIG, Small Business Administration OIG, and Department of Interior OIG investigation revealed that from August 2008 to April 2013, multiple set-aside and sole source contracts were awarded by VA and other Federal agencies, to include contracts involving *American Recovery and Reinvestment Act of 2009* funds, to various front companies controlled and financed by two of the defendants. These two defendants, who are husband and wife, submitted fraudulent documentation in order to obtain and maintain eligibility for the set-aside programs. The veteran defendant was determined to be a figurehead of the company, used only to qualify for the SDVOSB sole-source and set aside contracts. The loss to the Government is approximately \$14.8 million, with an approximate loss to VA of \$3.8 million.

**Pennsylvania Contractor Admits Hiring Veteran as "Straw" Partner To Obtain \$8M in Government Contracts Meant for Disabled Veterans**

A contractor pled guilty to participating in a conspiracy to defraud the United States as part of a scheme to receive an \$8.7 million SDVOSB set-aside contract. The defendant also agreed to the criminal forfeiture of more than \$2.4 million. The defendant admitted that the veteran with whom she partnered was merely a "straw person" and, contrary to

her representations to the Government, had no duties with the contract and accepted only a small annual payment so that his name and status could be used. The defendant also admitted that the contract company's project manager at a Federal building and another contractor participated in the scheme.

### **Missouri Man Pleads Guilty To Making False Claims Enabling Company To Win \$6.7M in Contracts Intended for Veterans**

The co-owner of a company pled guilty to conspiracy to commit fraud against the United States, major program fraud, and wire fraud. The contractor admitted that he and his father, a co-defendant, made false claims in order for their company to fraudulently obtain SDVOSB set aside contracts of \$6.7 million from VA and \$748,000 from the Department of Defense. Two other defendants have pled guilty in the case.

### **Former New England Compounding Center Supervisory Pharmacist Indicted for Mail Fraud**

A former New England Compounding Center supervisory pharmacist was indicted for mail fraud. A multi-agency investigation revealed that the defendant allegedly caused a shipment of contaminated methylprednisolone acetate vials to be labeled as injectable and fit for human use. The vials were ultimately shipped to pain clinics and used on patients. The contaminated vials resulted in the death or severe illness of numerous patients who received the injections. VA received several products from New England Compounding Center, including the methylprednisolone acetate. Two veterans were identified as having died as a result; however, they had received the contaminated medicine from non-VA providers.

### **Veteran Pleads Guilty to Theft of Government Funds**

A veteran pled guilty to theft of Government funds. An OIG and Department of State Diplomatic Security Service investigation revealed that the defendant fraudulently enlisted in the U.S. Army by using his cousin's identity after being discharged and barred from re-enlistment under his true identity. The defendant's fraud was identified during a Diplomatic Security Service passport investigation. The defendant admitted to using his cousin's identity in order to fraudulently re-enlist and obtain VA compensation, education, and medical benefits. The loss to VA is \$1,441,470.

### **Tuskegee, Alabama, VAMC Compensated Work Therapy Participant Arrested for Sexual Abuse at the Tuskegee, AL, VAMC**

A Tuskegee, AL, VAMC Compensated Work Therapy participant was indicted and arrested for sexual abuse. An OIG, VA Police Service, and Federal Bureau of Investigation (FBI) investigation determined that the defendant assaulted a handicapped VA Volunteer Services worker at the VAMC. The defendant was ordered held without bond pending trial.

### **Son of a VA Physician Arrested for Aggravated Assault at the Memphis, TN, VAMC**

The son of a VA physician was arrested for aggravated assault after stabbing his father multiple times at the Memphis, TN, VAMC. An OIG, VA Police Service, FBI, and

Memphis Police Department investigation determined that the defendant traveled from Virginia to Tennessee and attacked his estranged father with a knife.

**Veteran Arrested for Assault and Criminal Threats at the Long Beach, CA, VAMC**

A veteran was arrested for assault and criminal threats. An OIG and VA Police Service investigation revealed that the defendant arrived at the Long Beach, CA, VAMC and threatened to kill himself, his girlfriend, and three VAMC police officers. The defendant also assaulted two of the officers while attempting to leave the VAMC. During the investigation, a handgun and two rifles were subsequently recovered, weapons that the defendant was not authorized to possess. The veteran was later charged with possession of firearms by a prohibited person.

**Veteran Arrested for Making Criminal Threats at the Long Beach, CA, VAMC**

A veteran was arrested for making criminal threats. An OIG and VA Police Service investigation revealed that the defendant threatened to shoot his physician and other VA employees at the Long Beach, CA, VAMC.

**VA Employee Arrested for Making Threats at the North Little Rock, AR, VAMC**

A VA employee, who is also a veteran, was arrested for making threats. An OIG investigation revealed that the defendant contacted the North Little Rock, AR, VAMC and threatened to kill other VA employees. OIG agents, assisted by the U.S. Marshals Service, executed an arrest and search warrant at the defendant's residence and seized a handgun, drugs, and numerous stolen industrial cleaning supplies from the VAMC. The defendant is currently being held without bond and additional charges are pending.

**Former Long Beach, California, VAMC Housekeeping Aide Sentenced for Threats**

A former Long Beach, CA, VAMC housekeeping aide was sentenced to 585 days' incarceration and 3 years' probation after pleading nolo contendere to criminal threats. An OIG, VA Police Service, and FBI Joint Terrorism Task Force investigation revealed that the defendant made threatening statements toward the VAMC and a VA police officer.

**Fiduciary Sentenced for Grand Theft**

A veteran's son, acting as his fiduciary, was sentenced to 150 days' incarceration, 3 years' probation, and ordered to pay restitution of \$75,000 after pleading guilty to grand theft. An OIG investigation revealed that the defendant used the VA funds, as well as other assets of his father, for his personal use while neglecting to pay his father's assisted living facility bills.

**Former VA Fiduciary Sentenced for Theft**

A former VA fiduciary was sentenced to 30 months' incarceration and 3 years' supervised release after pleading guilty to theft of Government funds. A VA OIG, Social Security Administration (SSA) OIG, Railroad Retirement Board OIG, and the Montana Attorney General investigation revealed that the defendant embezzled \$369,585 of SSA, VA, and Railroad Retirement funds while operating a for profit fiduciary business.

**San Francisco, CA, VAMC Anesthesiologist Arrested for Possession of a Controlled Substance**

A San Francisco, CA, VAMC anesthesiologist was arrested for possession of a controlled substance. An OIG, DEA, and local police investigation revealed that the defendant surrendered her DEA registration after emergency personnel treated her for an apparent overdose of ketamine and fentanyl. A day prior to the emergency call, the defendant logged into the VAMC AcuDose-Rx dispensing cabinet and recorded that she had wasted injectable ketamine and fentanyl. The defendant subsequently confessed to possessing narcotics at her residence without a prescription and overdosing on the drugs. The defendant was subsequently terminated by VA for failure to maintain a current certification.

**Former Fort Harrison, Montana, VAMC Nurse Sentenced for Drug Diversion**

A former Fort Harrison, MT, VAMC nurse anesthetist was sentenced to 5 years' supervised release and barred from employment as a nurse after pleading guilty to acquiring controlled substances by fraud and deception. An OIG investigation revealed that the defendant was diverting and using sufentanyl and other controlled substances while performing his duties as a VA nurse.

**Gainesville, Florida, VAMC Nursing Assistant Sentenced for Theft**

A Gainesville, FL, VAMC nursing assistant was sentenced to 18 months' incarceration after pleading guilty to elder abuse, larceny, grand theft, and fraud. An OIG investigation revealed that the defendant stole funds from an elderly VA patient's bank account.

**Deceased Veteran's Daughter Charged with Theft of Government Funds**

The daughter of a deceased veteran was charged in a criminal information with theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole VA benefits that were direct deposited into a joint checking account after her father's death in January 1991. The defendant also stole SSA benefits that were direct deposited into a savings account of the veteran and his deceased spouse. Additionally, in July 2004 the defendant sent VA a letter and a Declaration of Status of Dependents, both of which were purported to have been signed by the deceased veteran. The loss to VA is \$572,717, and the loss to the SSA is \$58,633.

**Husband of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds**

The husband of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA funds that were direct deposited to a joint account after his wife's death in April 2004. The loss to VA is \$75,815.

**Business Owner Indicted for Theft**

A business owner was indicted for mail fraud, bank fraud, passing a forged endorsement on a U.S. Treasury check, theft of Government property, and aggravated identity theft. An OIG investigation revealed that before her death, a widow beneficiary

had her VA benefits mailed to a private mailbox business operated by the defendant. The defendant then stole, forged, and negotiated VA benefit checks that were issued after the beneficiary's death in February 2001. The loss to VA is \$116,598.

### **Veteran Sentenced for Interstate Transportation of Stolen Property from Chillicothe, OH, VAMC**

A veteran was sentenced to 24 months' incarceration and 3 years' supervised release after pleading guilty to interstate transportation of stolen property. An OIG investigation revealed that the defendant stole VA construction equipment and VA contractor equipment from the Chillicothe, OH, VAMC. Some of the stolen VA construction equipment was subsequently transported and sold by the defendant in West Virginia. The defendant admitted to transporting and selling the stolen property, as well as selling some of the stolen equipment at a local pawn shop. A stolen generator was also recovered during a search of the defendant's residence. The value of the stolen property transported to West Virginia is approximately \$89,200.

### **Former Bank Manager Arrested for Theft by a Bank Officer**

A former bank manager was arrested for theft by a bank officer. An OIG investigation determined that while the defendant was employed by a bank he became aware that a veteran had died in the Dominican Republic. VA was unaware of the veteran's death and continued depositing VA compensation benefits into the veteran's account. The defendant then embezzled the VA funds and funds from another bank customer to support a gambling habit. The loss to VA is \$37,830.

### **Veteran Placed on Deferred Prosecution for Theft**

A veteran signed a deferred prosecution agreement, deferring an indictment for 18 months that had charged him with wire fraud and theft. The defendant was also ordered to pay restitution of \$68,000. An OIG investigation revealed that the veteran failed to report to VA his income from leasing farmland. The loss to VA is \$80,656.

### **Veteran Pleads Guilty to Defrauding a Government Program**

A veteran pled guilty to defrauding a Government program. A VA OIG and SSA OIG investigation revealed that the defendant fraudulently applied for and received VA and SSA benefits. The defendant failed to report his employment income to VA and SSA. The loss to VA and SSA is approximately \$50,000.

### **Former United Parcel Service Employee Sentenced for Possession of a Controlled Substance**

A former United Parcel Service employee was sentenced to 3 years' supervised probation, ordered to complete a drug and alcohol abuse assessment, and to pay a \$2,000 fine and restitution of \$195 after pleading guilty to possession of a controlled substance with intent to sell or deliver. An OIG investigation revealed that during a 2-week period the defendant stole 1,520 tablets of VA controlled substances from 8 United Parcel Service packages. The investigation also revealed that the defendant used and sold the stolen tablets.

**Veteran Sentenced for Obtaining a Controlled Substance by Fraud**

A veteran was sentenced to 11 months and 29 days' incarceration (suspended) and 11 months and 29 days' probation after pleading guilty to obtaining a controlled substance by fraud. An OIG investigation revealed that the defendant received narcotics from a VA provider and non-VA provider during the same time period.



Richard J. Griffin  
Acting Inspector General