



# Department of Veterans Affairs

## Office of Inspector General

### December 2014 Highlights

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#### **OIG REPORTS**

##### **Review Finds Physicians Did Not Thoroughly Assess Patients Before Renewing Opioid Prescriptions at Chillicothe, Ohio VA Medical Center**

The Office of Inspector General (OIG) conducted an inspection in response to allegations that physicians at the Chillicothe, OH, VA Medical Center (VAMC) prescribed opioid medications for patients they had never evaluated. In addition, patients were alleged to be at risk because no prescriber was monitoring them for adverse reactions, pain relief, or opioid abuse. OIG did not substantiate that physicians improperly prescribed opioid medications for patients whom they had not seen or examined. OIG did substantiate that physicians prescribed opioids for patients with whom they had no direct interaction, but this is not a violation of law or VA policy. OIG substantiated that physicians did not consistently document medication effectiveness prior to renewing prescriptions for patients at increased risk for adverse medication effects or diversion. OIG also found that physicians were not consistently documenting use of the Ohio Automated Rx Reporting System, a state prescription drug monitoring program. OIG did find that urine drug screens were routinely performed. According to Veterans Health Administration (VHA) policy, patients on chronic opioid therapy are to be evaluated every 1 to 6 months. Although renewing opioid prescriptions without examining patients is not a violation of law or VA policy, a minimum review of patient information is required. OIG's review of 88 patients for whom opioids were prescribed in 2013 and 2014, and who were at increased risk for complications or abuse of opioids, revealed that physicians did not thoroughly assess patients before renewing opioid prescriptions. OIG recommended that the Facility Director ensure that patients receiving recurrent prescriptions for high potency and/or large quantities of opioid medications are routinely identified and provided appropriate follow-up care, and prescribing physicians review the prescription history reports contained in the Ohio Automated Rx Reporting System for patients who are prescribed opioids.

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

##### **Homeless and At-Risk Veterans Experience Problems Accessing VA's National Call Center for Homeless Veterans**

VHA's National Call Center for Homeless Veterans (the Call Center) is VA's primary vehicle for communicating the availability of VA homeless programs and services to veterans and community providers. The OIG has assessed the effectiveness of the Call Center in helping veterans obtain needed homeless services. OIG determined that homeless and at-risk veterans (homeless veterans) who contacted the Call Center often experienced problems either accessing a counselor and/or receiving a referral after completing the Call Center's intake process. Of the estimated 79,500 homeless veterans who contacted the Call Center in fiscal year (FY) 2013: Just under 21,200 (27 percent) could only leave messages on an answering machine—counselors were unavailable to take calls; almost 13,000 (16 percent) could not be referred to VA medical facilities—their messages were inaudible or lacked contact information; and

approximately 3,300 (4 percent) were not referred to VA medical facilities, despite having provided all the necessary information. Referred homeless veterans did not always receive the services needed because the Call Center did not follow up on referrals to medical facilities. Of the approximately 51,500 referrals made in FY 2013, the Call Center provided no feedback or improvements to ensure the quality of the homeless services. OIG noted that 85 percent of the 60 veterans' records OIG reviewed lacked documentation to prove the veterans had received needed support services. Finally, the Call Center closed just under 24,200 (47 percent) referrals even though the VA medical facilities had not provided the homeless veterans any support services. In total, OIG identified 40,500 missed opportunities where the Call Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services from VA medical facilities. OIG recommended the Interim Under Secretary for Health (USH) stop the use of the answering machine, implement effective Call Center performance metrics to ensure homeless veterans receive needed services, and establish controls to ensure the proper use of Call Center special purpose funds. The Interim USH concurred with OIG's recommendations and provided responsive action plans. OIG will follow up on these actions. [\[Click here to access report.\]](#)

### **VHA Lacks Assurance That National Consult Reviews Were Properly Resolved, Key Statements in Fact Sheet Were Misleading**

OIG evaluated VHA's review of "unresolved" consults and the accuracy of VA's summary, the National Consult Delay Review Fact Sheet (Fact Sheet), as requested by the Chairman of the House Veterans' Affairs Committee (HVAC). Unresolved consults are requests for consultations that are open or active in patients' electronic health records. In September 2012, VHA initiated a multi-phased review of consults that were unresolved for more than 90 days. By May 2014, the number of unresolved consults had decreased considerably. However, because VHA did not implement appropriate controls, OIG found it lacks reasonable assurance that facilities appropriately reviewed and resolved consults; closed consults only after ensuring veterans had received the requested services, when appropriate; and, where consult delays contributed to patient harm, notified patients as required by VHA policy. OIG's review of the Fact Sheet found several key statements related to the scope and results of VHA's review of unresolved consults were misleading or incorrect. These statements were repeated by VHA leaders at meetings with congressional staff and during media events. In July 2014, VHA issued a letter to the Chairman of the HVAC that included information intended to clarify statements in the Fact Sheet. OIG recommended that the Interim USH: (1) conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review; (2) ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm that patients have received appropriate care; and (3) after reviewing the circumstances of any inappropriate resolution of consults, confer with the Office of Human Resources and the Office of General Counsel or other relevant agency to determine the appropriate administrative action to take, if any. [\[Click here to access report.\]](#)

**OIG's Follow-Up Review of Columbia, South Carolina, VAMC Shows More Improvement Needed, New Issues Also Noted**

At the request of Members of the House and Senate Committees on Veterans' Affairs, OIG conducted an evaluation of conditions identified in its initial report *Quality of Care, Management Controls, and Administrative Operations* (Report No. 13-00872-71, issued February 6, 2014), at the William Jennings Bryan Dorn VAMC, Columbia, SC. The purpose of this follow-up review was to determine whether identified conditions have abated, continued unchanged, or worsened and whether OIG's recommendations were implemented. In the initial report, OIG noted that critical leadership positions were filled by a series of "acting" and temporary managers over a period of several years which contributed to past delays in correcting identified deficiencies. A permanent Chief of Staff and Medical Center Director were installed in January and April 2014 respectively, which has accelerated the VAMC's progress in addressing deficient conditions. However, many of the problems outlined in OIG's initial hotline report still existed, in whole or in part, at the time of OIG's follow-up visit (July 2014). OIG found that the VAMC had implemented corrective actions in response to the 12 recommendations in OIG's initial report, yet improvements were still needed. OIG agreed with closure of 2 recommendations and will continue to follow up on the remaining 10 recommendations from the initial report. In addition, during the July 2014 visit, OIG found improper storage of patient information, medical and surgical supplies, medications, grafts, and patches. OIG made one additional recommendation related to proper storage. [\[Click here to access report.\]](#)

**Security Control Weaknesses at Massachusetts VA Research Center Put Veterans' Personal Information at Risk**

In August 2013, the Senate Committee on Veterans' Affairs asked the OIG to review allegations that the Massachusetts Veterans Epidemiology Research and Information Center's (MAVERIC) security control weaknesses put veterans' personal information and other sensitive information at risk. It was also alleged that the Boston Healthcare System (BHS) leased off-site commercial office space for MAVERIC staff that the complainant considered wasteful. OIG substantiated the allegation that MAVERIC security control weaknesses put veterans' personal information and other sensitive information at unnecessary risk. In December 2013, OIG found hard copy veterans' personal information and unencrypted portable data storage devices unsecured in MAVERIC office space. VHA's Office of Research Oversight (ORO) found similar issues in August 2013 when it conducted a review of BHS research groups. In light of the issues identified during OIG's review and by ORO, OIG concluded that BHS had not taken sufficient action to safeguard the confidentiality of veteran personal information. This occurred because BHS did not establish sufficient oversight of MAVERIC physical security controls, such as ensuring secure storage of veterans' personal information and encryption of portable storage media. OIG also substantiated the allegation that BHS leased off-site commercial office space, which OIG determined was underutilized. BHS entered into a 5-year lease totaling about \$938,000 without determining how much office space it needed and whether there was available VA space. As a result, OIG estimates BHS could spend about \$593,000 over the 5-year lease period for underutilized office space. OIG recommended the Director of Veterans Integrated

Service Network (VISN) 1, in conjunction with the Office of Information and Technology, improve oversight of MAVERIC physical security controls and implement a plan to maximize use of the off-site commercial space if continued need for the office space is justified. The Director of VISN 1 concurred with OIG's recommendations and provided acceptable action plans. [\[Click here to access report.\]](#)

### **OIG Makes 11 Recommendations To Improve Access to Care at El Paso Health Care System**

OIG's Office of Healthcare Inspections conducted a review in response to concerns raised by Congressman Beto O'Rourke regarding access to care and productivity at the El Paso VA Health Care System (EPVAHCS). The purpose of this review was to determine the extent to which those concerns had merit. OIG substantiated the concerns expressed. OIG found that many veterans seeking care at the EPVAHCS faced challenges accessing care timely, particularly patients who were new to EPVAHCS. The timeliness of veterans' access to care exceeded the 30-day benchmark established by the VA Secretary for three of four specialties included in OIG's review—orthopedics, urology, and cardiology. In contrast, three EPVAHCS clinics met the 30-day access benchmark—primary care, mental health care, and gastroenterology. OIG also found that numerous factors affected the timeliness of veterans' access to care at the EPVAHCS, including staffing, productivity, and clinic cancellations and no shows. OIG explored these factors, as well as other key issues and management challenges described by officials OIG interviewed, and their impact on access. Efforts to improve access at the EPVAHCS should consider the factors OIG described in this report, both individually and in combination. OIG made 11 recommendations. [\[Click here to access report.\]](#)

### **Delays Identified in Reporting Incidents to Patient Safety Manager at West Palm Beach VAMC, Quality Management Understaffing Noted**

OIG conducted an inspection in response to a letter forwarded by Florida Governor Rick Scott. The letter contained multiple allegations about the quality of care at the West Palm Beach VAMC, West Palm Beach, FL. OIG did not substantiate that events related to patient falls resulting in injury and the deaths of two patients were not reported or investigated. However, OIG found that the investigation of one of the seven patient falls that OIG reviewed was not timely. OIG did not substantiate the allegation that a patient missed a scheduled chemotherapy treatment; however, completion of the patient's chemotherapy was delayed, and the incident was not reported to the Patient Safety Manager (PSM) as required. OIG did not substantiate the allegation that a patient was inappropriately given medication during a cardiac arrest or that the patient's death was not properly reported or investigated; however, OIG found that the correct progress note was not used, resulting in the Risk Manager not initiating the required review. OIG substantiated the allegation that a patient had the wrong lens implant placed in his eye during cataract surgery because the operative team failed to properly perform the time-out process. The PSM was not notified of the incident immediately, as required, using the Critical Incident Tracking Notification system. OIG did not substantiate the allegation that facility staff "covered up" or failed to disclose adverse events. OIG found that local policy for reporting patient incidents and/or safety

concerns was not being followed, causing unnecessary delays and missed opportunities for early intervention. Although not an allegation, OIG found that Quality Management Service has been chronically understaffed. OIG made four recommendations.

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

### **Sole-Source Contracts Inappropriately Awarded to Company Owned by Friends of Management at VA Technology Acquisition Center**

OIG's investigation and review substantiated allegations relating to the award and administration of contracts to Tridec Technologies (Tridec) for the Virtual Office of Acquisition (VOA) software development project. The contracts, valued at more than \$15 million, were awarded sole-source to Tridec by VA's Technology Acquisition Center utilizing the provisions of Title 38 U.S. Code § 8127. The review substantiated that VA management officials, one of whom had a personal relationship with one of Tridec's owners, split the requirements to ensure that Tridec was awarded the contracts without competition. Two former VA management officials, one of whom was a personal friend of one of Tridec's owners, engaged in lack of candor when interviewed by OIG Special Agents. A previous OIG audit substantiated allegations that VOA was not managed under the control and oversight of VA's Project Management Accountability System and was, in part, unnecessary. [\[Click here to access report.\]](#)

### **Combined Assessment Program Reviews**

In December 2014, OIG published one Combined Assessment Program (CAP) review containing OIG findings for the facility listed below. The purpose of the CAP review was to evaluate selected health care facility operations. The review covered the following six activities: (1) quality management, (2) environment of care, (3) coordination of care, (4) acute ischemic stroke care, (5) community living center resident independence and dignity, and (6) magnetic resonance imaging (MRI) safety.

#### **[VA Northern California Health Care System, Mather, California](#)**

### **Community Based Outpatient Clinic Reviews**

In December 2014, OIG published one Community Based Outpatient Clinic (CBOC) review 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 review was to evaluate three operational activities: (1) alcohol use disorder, (2) medication management, and (3) environment of care.

#### **[Central Alabama Veterans Health Care System, Montgomery, Alabama](#)**

### **CRIMINAL INVESTIGATIONS**

#### **Houston, Texas, VAMC Contract Specialist Indicted for Misapplication of Fiduciary Property**

A Houston, TX, VAMC contract specialist was indicted for misapplication of fiduciary property. A VA OIG and Small Business Administration OIG investigation revealed that the defendant awarded an overpriced sole-source contract to her common-law husband's business. The contract is worth approximately \$150,000.

**Former Palo Alto, California, VAMC Engineer Indicted for Receiving Bribes**

A former Palo Alto, CA, VAMC engineer was indicted for receiving an illegal gratuity by a public official. An OIG and Federal Bureau of Investigation (FBI) joint investigation revealed that while acting as a Contracting Officer's Representative (COR) on a \$1,488,802 MRI installation project, the defendant received \$7,000 in cash from a VA sub-contractor. Additionally, the defendant received \$9,230 of roofing work on his residence that was paid for by another VA contractor. After providing the illegal gratuities, the contractors received favorable treatment by VA.

**Former Palo Alto, California, VAMC COR Sentenced for Bribery**

In a separate case, a former Palo Alto, CA, VAMC COR was sentenced to 60 days' incarceration, 3 years' probation, and a \$7,500 fine after pleading guilty to bribery. An OIG and FBI investigation revealed that the defendant accepted approximately \$32,400 in bribes and gifts in exchange for ensuring that certain VA contractors received continuous work. Sentencing hearings are pending for three other co-defendants.

**Fourteen Defendants Indicted for Involvement with Nationwide Fungal Meningitis Outbreak**

Twelve defendants were arrested after being indicted for their involvement in the 2012 nationwide fungal meningitis outbreak. Two additional defendants were also indicted and are pending arrest. An OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, FBI, Defense Criminal Investigative Service (DCIS), and U.S. Postal Inspection Service investigation revealed that the outbreak was caused by contaminated vials of methylprednisolone acetate (MPA) manufactured by the New England Compounding Center (NECC). Sixty-four patients who received the contaminated doses died and almost 700 others were diagnosed with a fungal infection. VA purchased several products from NECC, including MPA, but no VA patients were affected. It is alleged that all NECC products were falsely represented to NECC customers, including VA. The owner and head pharmacist were each charged with second-degree murder, and the 12 other defendants, all associated with NECC, were indicted on charges to include racketeering, mail fraud, conspiracy, contempt, structuring, and violations of the Food, Drug, and Cosmetic Act. In addition to the contaminated vials of MPA, the indictment alleges that NECC's employees knowingly made and sold numerous drugs in a similar unsafe manner and in unsanitary conditions. Also, the investigation determined that NECC repeatedly took steps to shield its operations from regulatory FDA oversight by claiming to be a pharmacy dispensing drugs pursuant to valid, patient-specific prescriptions when, in fact, NECC routinely dispensed drugs in bulk without valid prescriptions.

**Former State of Maryland VA Employee Sentenced for Extortion**

A former State of Maryland VA employee was sentenced to 366 days' incarceration and ordered to pay \$1,284,399 after pleading guilty to extortion under the "Hobbs Act." From 2003 to 2011, while working at the State of 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. An OIG investigation revealed that the defendant 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, were insulin dependent, and the fraudulent DD-215s were used as proof of service in Vietnam. The State employee also filed a fraudulent DD-215 form to increase his own disability rating. A total of 17 veterans received compensation benefits using the fraudulent forms. The loss to VA is \$1,151,219. The defendant also assisted the veterans in receiving \$255,555 in property tax waivers from the State that they were not entitled to receive.

### **Defendant Convicted of Assaulting a VA Police Officer at the Central Arkansas Veterans Health Care System in Little Rock, Arkansas**

A defendant was convicted at trial of assaulting a Federal police officer with a deadly or dangerous weapon. An OIG and VA Police Service (VAPS) investigation revealed that the defendant and her sister, neither of whom are veterans, were soliciting money at the Central Arkansas Veterans Health Care System (CAVHCS) in Little Rock, AR when a VA police officer approached them. The defendant ignored an order to stop and subsequently injured the police officer with her vehicle as she fled the medical center.

### **North Little Rock, Arkansas, Healthcare Employee Indicted for Making Threats Against a Federal Official**

A VA employee was indicted for making threats against a Federal official. An OIG investigation disclosed that the defendant threatened to kill VA employees and also referenced going on a mass shooting spree at the CAVHCS facility in North Little Rock, AR. The defendant is currently being held without bond.

### **Veteran Sentenced for Making Terroristic Threat**

A veteran was sentenced to 2 years' probation after pleading guilty to making a terroristic threat. An OIG investigation revealed that during a recorded call to a VISN Telephone Care Service the defendant threatened to kill both a VA physician assistant and a Federal Administrative Law Judge.

### **Veteran Convicted of Criminal Threats and Resisting Arrest at the Long Beach, California VAMC**

A veteran was convicted for making criminal threats and resisting arrest. The court also ordered that the veteran undergo a 90-day diagnostic test before sentencing. An OIG and VAPS investigation revealed that the defendant arrived at the Long Beach, CA, VAMC and threatened to kill himself, his girlfriend, and three VA police officers. The defendant also assaulted two of the officers while attempting to leave the medical center. During the investigation, a handgun and two rifles were recovered. The defendant was not authorized to possess these weapons.

### **Veteran Arrested for Harassing VA Employee**

A veteran was arrested for aggravated harassment after an OIG, state police, and VAPS investigation revealed that the veteran, during treatment at a VA Community Day Program Center, touched a female VA employee and then continually harassed her by telephone. The employee was granted an order of protection by a judge who also ordered the defendant be psychologically evaluated.

**Former VA-Appointed Fiduciary Sentenced for Embezzlement**

A former VA-appointed fiduciary was sentenced to 5 years' supervised probation and ordered to pay VA restitution of \$30,240 after pleading guilty to embezzlement. An OIG investigation revealed that the defendant, as the fiduciary, failed to notify VA that a widow beneficiary had died. The defendant subsequently received and negotiated VA benefit checks issued after the beneficiary's death in April 2009 and used the funds for personal expenses.

**Co-Conspirator Sentenced for Conspiracy, Forgery, and Identity Theft**

A fourth and final co-conspirator was sentenced to 46 months' incarceration, 3 years' probation, and ordered to pay \$128,320 in restitution after pleading guilty to conspiracy to pass forged U.S. Treasury checks, forged securities, and identity theft. An OIG and U.S. Secret Service investigation revealed that the defendant and co-conspirators stole the identities of numerous individuals, filed fraudulent tax returns, and forged and negotiated VA benefit checks.

**Former Chief Executive Officer of a Non-Profit Company Indicted for Obstruction of an Audit**

A former Chief Executive Officer of a non-profit company was indicted for obstruction of an audit. An OIG investigation revealed that the defendant made false representations by inflating the value of property when applying for a grant to provide funds for the purchase of property to be used to house indigent veterans. Six days after the purchase of the property the non-profit company received a \$50,000 kickback from the seller.

**Two Non-Veterans Plead Guilty to Fraud and Identity Theft**

Two non-veterans pled guilty to various fraud and identity theft charges. An OIG, Internal Revenue Service Criminal Investigations Division, and local sheriff's office investigation revealed that the defendants used veteran's stolen personal identifiable information to commit tax fraud in excess of \$610,000.

**Veteran Convicted of VA Compensation Fraud**

A veteran was found guilty at trial of wire fraud and theft of Government funds. An OIG investigation revealed that the veteran submitted an additional claim to VA for disability benefits, falsely claiming exposure to Agent Orange while serving in Vietnam for 2 months in 1965. The veteran was subsequently awarded 100 percent disability with individual unemployability. The investigation further determined that the veteran's only overseas duty was in Germany. The loss to VA is \$456,649.

**Veteran Pleads Guilty to VA Compensation Fraud**

A veteran pled guilty to theft of public money after an OIG investigation revealed that he fraudulently received VA compensation benefits based on an altered DD-214 that he falsified in 1970 by claiming multiple combat awards, including two Purple Hearts and a Silver Star. Approximately 30 years later, the defendant submitted a fraudulent application to VA seeking compensation for post-traumatic stress disorder (PTSD) and shell fragment wounds. The defendant claimed to have participated in hand-to-hand

combat and sustained bayonet wounds, a gunshot wound, and shrapnel wounds. The defendant claimed on VA forms and in discussions with VA physicians that he had survived these battle wounds and that he had killed numerous enemy combatants. Through a review of records, witness interviews, and the defendant's own admissions, OIG's investigation determined that the defendant did not receive any combat awards and did not suffer any combat injuries while in Vietnam. Also, the investigation determined that his scars were not related to injuries suffered in combat. From approximately October 1999 through July 2014, the defendant received \$174,656 in VA funds to which he was not entitled.

### **Veteran Sentenced for Fraudulent Acceptance of Payments**

A veteran was sentenced to 5 years' probation and ordered to pay VA restitution of \$61,000 after pleading guilty to the fraudulent acceptance of payments. An OIG investigation revealed that since 2003 the defendant had been collecting individual unemployability benefits while he was employed as a full-time security officer.

### **Son of a Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds**

The son of a deceased VA beneficiary pled guilty to theft of Government funds. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant stole VA Dependency and Indemnity Compensation and SSA benefits that were direct deposited after his mother's death in December 2009. The loss to VA is \$61,548, and the loss to SSA is approximately \$36,000.

### **Daughters of Deceased VA Beneficiaries Arrested for Theft of VA Benefits**

The daughter of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in July 2005. The loss to VA is \$133,924. Another daughter of a deceased beneficiary was arrested for theft of Government funds. An OIG investigation determined that the defendant stole VA funds that were direct deposited into a joint bank account after her mother's death in September 2005. The defendant admitted to stealing the funds and using them for personal expenses. The loss to VA is \$63,197.

### **Non-Veteran Pleads Guilty to Health Care Fraud**

A Roseburg, OR, VAMC outpatient, who falsely claimed to be a veteran, pled guilty to health care fraud. An OIG investigation determined that between April 2003 and April 2012 the defendant fraudulently received travel benefits, Housing and Urban Development Veterans Affairs Supportive Housing benefits, and health care from the medical center. The defendant initially falsified his application for VA health care benefits in 2002 and continued to apply for and receive additional VA benefits. The loss to VA is approximately \$32,000.

### **Former Dell Contractor Sentenced for Theft of Government Property**

A former Dell contractor assigned to the Jackson, MS, VAMC was sentenced to 4 months' incarceration, 3 years' supervised probation, 3 months' community confinement, and ordered to pay \$3,886 in restitution after pleading guilty to theft of

Government property. An OIG investigation revealed that the defendant used his position to steal and then sell VA computers. As a result of the investigation, stolen VA computer workstations and stolen VA laptop computers were recovered.

### **Former Palo Alto, California, VAMC Nurse Sentenced for Drug Diversion**

A former Palo Alto, CA, VAMC registered nurse was sentenced to 3 years' probation after pleading guilty to obtaining a controlled substance by fraud. An OIG investigation revealed that the defendant diverted approximately 1,200 syringes of hydromorphone totaling more than 3,850 milligrams. The defendant diverted these syringes by using the doses that she claimed to have given to patients, logging into the automated dispensing system under the profiles of other nurses and withdrawing doses, or initiating false wasting entries under both her profile and those of the other nurses.

### **Veteran Sentenced for Drug and Weapon Violations**

A veteran was sentenced to 20 months' incarceration after pleading guilty to knowingly, intentionally, and unlawfully possessing with intent to distribute a substance containing oxycodone and knowingly possessing and transferring a machine gun. Also, the veteran forfeited 15 assorted rifles, handguns, and 16,000 rounds of ammunition, which had been confiscated during a search of his residence. An OIG, Bureau of Alcohol, Tobacco, and Firearms, DCIS, and local police investigation revealed that the defendant participated in a conspiracy with at least two other veterans in the theft and transport of at least two machine guns stolen from Fort Bragg. Undercover purchases of the guns were conducted, and two separate arrests were made regarding those purchases. The defendant also sold a shotgun, ammunition, bulletproof vest, and his VA prescription medications to one of the previously arrested veterans.

### **Veteran Arrested for Obtaining Controlled Substances by Fraud**

A veteran was arrested for obtaining controlled substances by misrepresentation or fraud. A VA OIG and Health and Human Services OIG investigation revealed that the defendant used one name as a veteran to obtain controlled substances from VA and another name to obtain controlled substances from a State of Florida Medicaid program. For over 2 years, the defendant obtained several thousand Schedule II controlled substances from both VA and non-VA providers.

### **Veteran Arrested for Drug Distribution**

A veteran, who resided at the Bedford, MA, VAMC, was arrested for distribution of heroin after an OIG, Drug Enforcement Agency, and VAPS investigation determined that the defendant was selling illicit drugs to veterans receiving treatment for substance abuse. The investigation was initiated based on a history of illicit drugs being used at the VAMC, a history of drug overdoses, and concerns voiced by medical center staff.



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