



Department of Veterans Affairs

Office of Inspector General

March 2015 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Testifies Before House Appropriations Subcommittee on Military Construction and VA on How VA Can Improve Service to Veterans

Richard J. Griffin, Deputy Inspector General, testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, on the Office of Inspector General's (OIG) oversight of VA programs and operations. He focused on the OIG's recent work involving veterans' access to care, including the review of scheduling practices and poor care at the Phoenix VA Health Care System (PVAHCS), which was a watershed event for VA and OIG. As a result, OIG launched investigations at 98 VA medical care facilities into allegations that scheduling was manipulated to make wait times for outpatient appointments appear to be shorter than the actual wait times experienced by veterans. He explained the dramatic increase in the number of contacts to the OIG Hotline, in the number of inquiries sent to OIG by Members of Congress, and by veterans and their families since reporting on PVAHCS began last year. He also discussed Veterans Benefits Administration's (VBA) delivery of benefits and the need to improve financial stewardship of taxpayer funds, data integrity and overall claims management, and focus more efforts on addressing the timeliness and accuracy associated with processing veterans' claims. Mr. Griffin was accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections.

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

Assistant Inspector General for Healthcare Inspections Testifies Before the Senate Veterans' Affairs Committee on OIG's May 2014 National Opioid Report and Recommendations To Reduce Risk to Veterans

John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States Senate, on the OIG's May 2014 national report, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy*. He discussed results that indicate that VA is not following its own procedures for managing patients that are being treated with opioids. He noted that VA has taken action on four of the six recommendations in the report. Dr. Daigh also discussed overarching findings from OIG's reporting on opioid prescription practices since 2011, where we found that the use of high dose opioids in patients with a substance use disorder and mental illness is a common clinical situation; compliance with clinical guidelines is not routine; primary care providers bear the responsibility for managing these complex patients, often with limited support from pain management experts and related specialists; the use of high dose opioids causes friction within provider groups, where opinions on the proper use of these medications varies; and non-traditional therapies that may offer the benefit of less narcotic use are not fully utilized. [\[Click here to access testimony.\]](#)

Assistant Inspector General for Healthcare Inspections Testifies at Joint Congressional Field Hearing on Prescription Practices at the Tomah, Wisconsin, VA Medical Center, and VHA-Wide Opioid Review

John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections, testified at a field hearing of the Committee on Homeland Security and Governmental Affairs, United States Senate, and the Committee on Veterans' Affairs, United States House of Representatives, on March 30, 2015. The hearing was held in Tomah, WI, and focused on the prescription of opioids at the Tomah VA Medical Center (VAMC). Dr. Daigh focused on the issues raised in the OIG's *Healthcare Inspection – Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin*, and the results of the OIG's May 2014 national report, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy* and the national review which mirrored the time frame of our work in Tomah, shows that in 2012, VA providers were in general non-compliance with VA and Department of Defense clinical practice guideline requirements including the use of urine drug screens and follow up visits; the practice of refilling prescriptions at least 7 days early; the concomitant use of benzodiazepines and narcotic medications; or ensuring that veterans with substance use disorder and chronic pain receive concurrent treatment for their substance use disorder and urinary drug testing. The data as reported for fiscal year 2012, makes clear that VA as a system of care, was managing patients being treated with opioids very poorly. Dr. Daigh was accompanied by Alan Mallinger, M.D., Senior Physician, Office of Healthcare Inspections.

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

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

Counselor to the Inspector General Outlines Legal Requirements OIG Must Follow When Releasing Information to Congress

Maureen T. Regan, Counselor to the Inspector General, testified before the Committee on Veterans' Affairs, United States House of Representatives, at a hearing on "The Power of Legislative Inquiry – Improving the VA by Improving Transparency."

Ms. Regan provided information on the laws and requirements that OIG must follow when releasing information to Congress and the public. Ms. Regan explained that the OIG is transparent in reporting the findings and conclusions of OIG work as permitted under existing laws and regulations, and that OIG has complied with applicable legal requirements for reporting and responding to Congress. She also addressed issues regarding OIG's December 8, 2014, report on contracts awarded by VA's Technical Acquisition Center to Tridac Technologies for the Virtual Office of Acquisition, and the factual errors in a letter sent by the Department of Treasury Inspector General to the Committee Chairman and Ranking Member questioning the integrity of this report. Ms. Regan announced at the hearing that the Deputy Inspector General had referred the Treasury Inspector General's involvement in a VA matter to the Integrity Committee for the Council of the Inspectors General for Integrity and Efficiency for a full investigation, including the conduct of all individuals involved.

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

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

ADMINISTRATIVE INVESTIGATIONS

Fayetteville Healthcare System Employee's Involvement in Evaluation of Family's Property Created Appearance of Conflict of Interest

A Veterans Health Administration (VHA) Project Manager improperly participated as a member of a survey team, creating an appearance of a conflict of interest, when she did not recuse herself from the site selection process for a new health care center after realizing that properties to be reviewed were owned by her extended family members. As a VA employee and Professional Engineer she knew that her participation may be a conflict of interest, or perceived as one, and that she should have recused herself from the site selection process as soon as she realized a family connection to the properties. This process ultimately resulted in VA purchasing about 35 acres of land from her extended family member for about \$4.25 million. Further, VHA senior officials failed to properly discharge the duties of their positions when they individually learned of the possible conflict of interest and took insufficient action, and there were many discrepancies found within the records associated with the solicitation and purchase of this particular property. [\[Click here to access report.\]](#)

Former VHA Deputy Chief Business Officer for Purchased Care Committed Prohibited Personnel Practice, Others Misused Official Time

The former (retired) Deputy Chief Business Officer (DCBO) for Purchased Care (PC), engaged in a prohibited personnel practice when she gave preference in hiring to a former VA coworker and VA contractor employee. To reach her favored candidate, she created a program manager position, defined the scope and manner of competition through misuse of a non-competitive reinstatement authority for Federal employees, and defined the requirements of the position by writing the position description while she possessed the favored candidate's resume. In addition, an Office of Compliance and Business Integrity employee misused official time and resources, improperly exchanged information with two subordinates who did the same, when they engaged in investigative research on their supervisors outside the scope of their official duties, because the employee was not selected for a promotion to the Director of Program Oversight and Informatics position. [\[Click here to access report.\]](#)

OIG REPORTS

Veteran's Suicide Risk Not Properly Managed by Hampton VA Medical Center, Better Training for Staff and Contract Providers Needed

OIG conducted an inspection at the request of Senator Richard Burr to assess the merit of allegations received from a complainant concerning the clinical management of a veteran who reported a recent suicide attempt and failure to diagnose a cardiac condition at the Hampton VAMC, Hampton, VA. The veteran died several weeks after the reported suicide attempt. The medical examiner who performed an autopsy stated that "The manner of death is accident" and recorded the cause of death as the combined toxic effects of two medications, a narcotic pain reliever and an anti-anxiety medication, with severe disease of one coronary artery (a blood vessel that supplies the heart muscle) contributing to the death. OIG substantiated that the veteran's reported attempt to commit suicide was not managed as required by VHA policy. OIG found that although all but one of the clinical staff members in the VAMC's Emergency Department

and Mental Health clinics had completed suicide risk management training, they did not identify his suicide risk factors and did not report the veteran's recent suicidal behavior as required by VHA. OIG substantiated the allegation that the veteran suffered from undiagnosed heart disease. However, his complaints of chest pain and shortness of breath had been evaluated on several occasions. OIG found that his physical exam, laboratory studies, and four electrocardiograms were within normal limits and did not support a need for a further, more invasive evaluation. OIG found that contracted providers were not required to undergo suicide risk management training. OIG made two recommendations. The Veterans Integrated Service Network (VISN) and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan. [\[Click here to access report.\]](#)

Review Finds Delay Obtaining Magnetic Resonance Imaging at Goshen, Indiana, Community Based Outpatient Clinic

OIG conducted an inspection at the request of Congresswoman Jackie Walorski to assess care provided to a patient at the Goshen Community Based Outpatient Clinic (CBOC), Goshen, IN, who died of complications related to metastatic lung cancer. OIG determined that, although this patient's metastatic disease presentation was not typical, there was a delay in obtaining magnetic resonance imaging (MRI) after computed tomography results showed left rib involvement, and his quality of life could have been improved through an earlier diagnosis. OIG could not, however, determine that an earlier diagnosis would have changed his outcome. OIG also determined the patient and his wife were not aware of VA's Patient Advocacy Program. OIG made two recommendations. [\[Click here to access report.\]](#)

Audit Finds Immediate Action Needed To Address Weaknesses in VA Drug-Free Workplace Program

OIG conducted an audit to assess how effectively VA's Drug-Free Workplace Program identifies and addresses illegal drug use among VA employees. VA needs to improve management of its Drug-Free Workplace Program. VA selected about 3 of every 10 applicants for pre-employment drug testing before hiring these individuals into Testing Designated Positions (TDPs) in fiscal year (FY) 2013. OIG estimates that of the nearly 22,600 individuals VA reported hiring into TDPs in FY 2013, about 15,800 were hired without a pre-employment drug test. VA facilities tested about 68 percent of the 3,420 employees selected for random drug testing in FY 2013. OIG identified at least 19,100 employees in TDPs who were not subject to the possibility of monthly random drug testing. In addition, VA erroneously designated as many as 13,200 employees in non-TDPs for drug testing in FY 2014. Further, only 17 (33 percent) of the 51 employees who tested positive for drugs as a result of reasonable suspicion of on-the-job drug use or after a workplace accident or injury were referred to VA's Employee Assistance Program. These issues occurred because VA does not support that all tentative selectees for TDPs need to be drug tested before being hired. VA also does not effectively monitor local facility compliance with random employee drug testing requirements. Furthermore, VA lacks adequate oversight to ensure the accuracy of drug testing data and that consistent personnel actions are taken when employees test positive for drugs. As a result, VA has little assurance that this program is performing

as intended to identify and eliminate illegal drug use in its workforce. Since VA's workforce is expected to grow significantly with the passage of the Veterans Access, Choice, and Accountability Act of 2014, VA needs to take actions to address weaknesses in its Drug-Free Workplace Program immediately. OIG recommended the Deputy Assistant Secretary for Human Resources Management implement processes to ensure full compliance with VA's pre-employment applicant drug testing and random employee drug testing requirements, and improve program integrity by ensuring the accurate coding of employees in TDPs. The Acting Deputy Assistant Secretary for Human Resources Management concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions. [\[Click here to access report.\]](#)

VHA Violated Appropriations Law by Improperly Obligating \$92.5 Million Meant for Medical Support on Information Technology Development

OIG conducted a review in response to allegations received by OIG Hotline Division. OIG evaluated the merits of an allegation that VHA's Chief Business Office (CBO) violated appropriations law by improperly obligating over \$96 million in medical support and compliance (MS&C) funds to pay for the development of the Health Care Claims Processing System (HCPS). OIG substantiated that the CBO knowingly violated appropriations law by improperly obligating a total of \$92.5 million of MS&C appropriations to finance the development of HCPS. The difference between the alleged and substantiated amounts is due to an estimate cited by the complainant. Of the \$92.5 million, the Financial Services Center spent approximately \$73.8 million. However, \$18.7 million still remains obligated. MS&C appropriations are only authorized for administering medical, construction, supply, and research activities. CBO's misuse of MS&C appropriations occurred because the DCBO did not seek the required Information Technology (IT) Systems appropriations to fund the development of HCPS. Though initiated by the former DCBO for Purchased Care, MS&C appropriations were used instead of requesting funding from the Office of Information and Technology in hopes of achieving a faster delivery of this new information system. The current DCBO allowed the expenditures to proceed unchecked. As a result, the CBO violated appropriations law when it improperly obligated about \$92.5 million of MS&C appropriations to develop HCPS. OIG recommended the Interim Under Secretary for Health (USH) establish oversight mechanisms, seek the return of all MS&C appropriations, de-obligate all current MS&C funds, and obtain appropriate funding for HCPS development. OIG also recommended that the Interim USH determine if appropriate administrative action should be taken against DCBO senior officials in the PC's chain of command. The Interim USH concurred with OIG's findings and recommendations and plans to complete all corrective actions by September 30, 2015. OIG considered these planned actions acceptable and will follow up on their implementation. [\[Click here to access report.\]](#)

VHA Risks Improper Payments of \$56.2 Million if Controls for Emergency Transportation Claims Are Not Strengthened

OIG conducted an audit to determine the accuracy of payments for VHA's non-VA medical care emergency transportation claims. The Non-VA Medical Care Program

assists veterans who cannot feasibly receive care at a VA medical facility. Inaccurate payments affect VA's commitment to delivering timely and high quality health care to veterans while controlling costs. VHA's Non-VA Medical Care Program improperly paid 129 of 353 (37 percent) emergency transportation claims from April 1, 2013, through September 30, 2013. Of the total 353 payments valued at \$585,800, the 129 improper payments amounted to \$167,600. Non-VA medical care staff made the following improper payments: (1) \$19,300 for 27 of 353 claims (8 percent) to vendors that submitted a claim or required documentation untimely, (2) \$25,000 for 7 of 353 claims (2 percent) for care provided to ineligible veterans, and (3) \$123,300 for 95 of 353 claims (27 percent) for the incorrect amount. These claims were improperly paid because staff did not conduct an adequate review to ensure that all documentation was received prior to processing the claim and did not correctly determine veterans' eligibility for emergency transportation. Staff also misunderstood the criteria for processing non-service and service-connected emergency transportation claims. As a result, OIG projected an annual improper payment amount of approximately \$11.2 million. Over the next 5 years, OIG projected improper payments of approximately \$56.2 million if claims processing controls are not strengthened. OIG recommended the Interim USH implement periodic training and systematic reviews of emergency transportation claims, and instruct the sampled VA medical facilities to initiate recovery of overpayments and reimbursement of underpayments identified in this audit. The Interim USH concurred with OIG's recommendations and provided responsive action plans. OIG will follow up on these actions. [\[Click here to access report.\]](#)

Honolulu, Hawaii, VA Regional Office Supervisor's Removal of Electronic Controls Undermined Effectiveness and Misrepresented Inventory

On October 29, 2014, OIG received a request from the Director of the Honolulu, HI, VA Regional Office (VARO) asking that the OIG assess alleged data manipulation involving a supervisory employee from that office. Specifically, a Honolulu VARO fact-finding initiative revealed a supervisor improperly removed controls from an electronic record used to identify and process claims without taking the appropriate actions. Additionally, results from their fact-finding indicated this supervisor directed staff to disregard VBA policy when processing some claims. OIG substantiated the allegation that the supervisor inappropriately removed controls in the electronic record used to track and identify claims related to verifying the status of veterans' dependents without taking proper actions to complete the claims. OIG reviewed 139 cases and determined the supervisor inappropriately removed system controls for 100 benefits claims. The supervisor admitted to removing controls from the electronic record but stated it was not his intention to misrepresent data. Further, in one instance, OIG determined the supervisor instructed VARO staff to disregard VBA policy related to a claim involving recoupment of separation pay. The actions to remove claims from the electronic record misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may have continued to receive additional compensation for dependents that they were not entitled to receive. The inappropriate actions described in this report undermine program effectiveness. Therefore, OIG recommended the Honolulu VARO Director take immediate action to correct, as appropriate, all improper actions taken by the

supervisor. OIG also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee. The VARO Director concurred with OIG's recommendations and management's planned actions are responsive. OIG will follow up as required. The VARO Director informed OIG the supervisor who took the improper actions related to dependency claims resigned his position. [\[Click here to access report.\]](#)

Review of Gastroenterology Service at Lovell North Chicago, Illinois, Facility Finds Inconsistent Documentation of Non-VA Care in VA Records

OIG conducted an inspection in response to allegations of mismanagement of gastroenterology (GI) services and other quality of care deficiencies at the Captain James A. Lovell Federal Health Care Center (facility), North Chicago, IL. OIG received multiple allegations of "turmoil and chaos" related to a recent reorganization of senior leadership. OIG focused on prioritization of GI services, alleged quality of care deficiencies, requests for unnecessary GI procedures, and the lack of coordination of non-VA GI care. OIG substantiated allegations that facility gastroenterologists had been directed by facility leaders to prioritize care in favor of active duty service members and that scheduled GI procedures were limited to four per day. However, OIG found that the facility leaders' decision to prioritize care in favor of service members was made in accordance with a 2010 Department of Defense/VA Executive Agreement that outlines terms of operation for the facility and that veterans were receiving care when necessary through the Non-VA Medical Care Program. OIG substantiated a significant lapse in the management of a patient's low blood sugar. However, OIG found the facility had appropriately addressed the issue. OIG did not substantiate the allegations that an increase in falls, pressure ulcers, urinary tract infections, elopements, diversions, and wrong site procedures occurred as a result of senior leaders' mismanagement after a reorganization in spring 2014 or that facility leaders requested that GI staff perform unnecessary procedures. OIG also did not substantiate that the facility lacked a process for coordinating non-VA GI care. However, OIG did find inconsistencies in the posting of non-VA GI procedure results into the VA electronic health record. OIG recommended that the Facility Director ensure that documentation of procedure results from non-VA GI care providers is obtained and available in the electronic health record for review in a timely and consistent manner.

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

VHA Missed Telehealth Opportunities That Could Have Delayed Veterans' Need for Long-Term Care, More Specific Metrics Needed

The goal of the Home Telehealth Program is to improve veterans' access to care while reducing patient treatment costs. The program does this by remotely monitoring patients' vital signs in the home and intervening early when adverse trends are detected. OIG determined how effectively VHA is managing its Home Telehealth Program. VHA missed opportunities to expand enrollment for Non-Institutional Care (NIC) patients in the Home Telehealth Program. NIC telehealth patients showed the best outcomes, in terms of reduced inpatient admissions and bed days of care. In FY 2013, the number of NIC patients-served declined by 4 percent, while the number of Chronic Care Management and Health Promotion/Disease Prevention (HPDP) patients-

served grew 51 and 37 percent, respectively. The significant change in the mix of patients receiving care in this program occurred due to a change in the performance methodology. VHA began to measure program performance by the total number of patients-enrolled, rather than focusing on the increase in enrollment for NIC patients. This change in performance metrics encouraged VHA to enroll more HPDP participants. These participants would likely need less intervention from Primary Care physicians, because their health care needs would be less complex. VHA was successful in reaching its new performance metric. However, obtaining this goal did not result in more patients with the greatest medical needs receiving care under the program. As a result, VA missed opportunities to serve additional NIC patients who could have benefited from the Home Telehealth Program. VA could have potentially delayed the need for long-term institutional care for approximately 59,000 additional veterans in FY 2013. OIG recommended the Interim USH implement mechanisms to identify demand for NIC patients and develop specific performance measures to promote enrollment of NIC patients. The Interim USH concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions. [\[Click here to access report.\]](#)

Review Finds Inadequate Follow-Up of MRI Results at Charlotte, North Carolina, CBOC

OIG reviewed an allegation of improper notification of test results and delayed care at the Charlotte CBOC, Charlotte, NC. OIG did not substantiate the allegation that the patient was not properly notified of his MRI results. However, OIG found that the clinical process of discussing the test results, negotiating a treatment plan, and educating the patient about his condition did not comply with VHA guidelines. OIG substantiated the allegation that the patient's treatment was delayed. The primary care provider did not adequately follow up after receiving the patient's abnormal MRI results or follow through on the patient's plan of care. Failure to take clinical action may have contributed to a more complex clinical course for this patient. OIG made three recommendations. [\[Click here to access report.\]](#)

OIG Recommends Training in Wound Care Device at the Community Living Center, Charlie Norwood VAMC, Augusta, Georgia

OIG conducted an inspection in response to allegations concerning staffing and quality of care issues resulting in patient harm and death in the community living center (CLC) at the Charlie Norwood VAMC, Augusta, GA. OIG substantiated that the VAMC was without one of three registered nurse (RN) Certified Wound Care Specialists for over a year. OIG did not substantiate that several patients' wounds were neglected as a result of the vacancy. While OIG found that one patient had several pressure wounds, OIG determined that the care for this patient's wounds was acceptable. OIG substantiated the allegation that a patient had a wound vacuum assisted closure (VAC) device that nurses and physicians failed to maintain. OIG found that the sponge from the wound VAC adhered to the wound and required removal. OIG concluded that the lack of training may have contributed to a delay in care. OIG did not substantiate that the primary care provider failed to send a patient to the inpatient medical unit earlier during the day, which resulted in a code being announced later that evening. OIG also did not

find that the patient provided a written statement regarding the incident and that the VAMC failed to address it. OIG substantiated that a patient developed several wounds that needed debridement. However, OIG did not determine that it was due to the lack of an RN wound care specialist onsite. OIG recommended that the Facility Director require that all nursing staff in the CLC receive the required training on the wound VAC device. [\[Click here to access report.\]](#)

OIG Makes Two Recommendations To Improve Patient Telemetry Monitoring at Michael E. DeBakey VAMC, Houston, Texas

OIG conducted an inspection in response to allegations that untrained employees monitor inpatients on telemetry (portable device that allows continuous observation of a patient's heart rate and rhythm); that since January 2014, several inpatients on telemetry monitoring have died who potentially could have been saved if nursing staff were alerted rapidly to observed cardiac arrhythmias; and that the new telemetry monitoring equipment installed in February 2013 does not allow patient monitoring in a safe and effective way at the Michael E. DeBakey VAMC, Houston, TX. OIG did not substantiate the allegation that untrained employees were monitoring inpatients who were on telemetry. OIG did not substantiate the allegation that patients on telemetry, during the period January 1, 2014, through July 18, 2014, died who potentially could have been saved if telemetry staff had notified nursing staff of observed cardiac arrhythmias. However, of the 40 telemetry patients with facility-conducted mortality reviews, OIG found documentation of 18 (45 percent) patients with a "hospice" or "comfort care" status. OIG did not substantiate the allegation that the new telemetry monitoring equipment installed in February 2013 prevents patients on telemetry from being monitored in a safe and effective way. OIG did not find staff sleeping; however, OIG did find that some unit staff were not carrying the facility-required telephones used for direct communication between telemetry and unit staff. OIG revisited the same areas during the day shift and found staff on two of the same units not carrying the required telephones. OIG recommended that the Facility Director ensure that the appropriateness of assigning patients to telemetry is reviewed. OIG also recommended that the Facility Director ensure dedicated wireless telephones are continuously carried by unit charge nurses or designees for effective communication between unit and telemetry monitoring technicians as required by local policy.

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

Results of Benefits Inspection at Fargo, North Dakota, VARO

OIG evaluated the Fargo VARO to see how well its staff processes disability claims and provides a range of services to veterans. OIG sampled three types of disability claims that OIG considered at increased risk of processing errors, temporary 100 percent disability evaluations, traumatic brain injury (TBI), and special monthly compensation (SMC) and ancillary benefits. These results do not represent the overall accuracy of disability claims processing at this VARO. However, VARO staff did not accurately process 12 of 49 disability claims (24 percent) reviewed. In OIG's previous report, *Inspection of the VA Regional Office, Fargo, North Dakota* (Report No. 11-03724-73, January 25, 2012), OIG identified that the most frequent processing errors associated with temporary 100 percent disability evaluations resulted from staff not establishing

electronic controls needed to request medical reexaminations to reevaluate the severity of disabilities. During the October 2014 inspection, OIG did not identify similar errors. Therefore, OIG determined the Veterans Service Center's (VSC) actions in response to the national review plan have been effective. VARO staff established correct dates of claim in the electronic record for 29 of the 30 claims reviewed. However, staff did not timely or accurately complete 4 of 30 proposed benefits reduction cases. OIG recommended the Fargo VARO Director ensure staff review the 40 temporary 100 percent disability evaluations within the universe of claims that were pending at the VARO as of August 21, 2014, ensure staff receive training regarding proper procedures for establishing permanent disability evaluations, and implement a plan to ensure staff address all pending issues related to SMC and ancillary benefits. The Director of the Fargo VARO concurred with all recommendations. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Results of Benefits Inspection at Manchester, New Hampshire, VARO

OIG evaluated the Manchester VARO to see how well its staff processes disability claims and provides a range of services to veterans. OIG sampled three types of disability claims considered at increased risk of processing errors, temporary 100 percent disability evaluations, TBI, and SMC and ancillary benefits. These results do not represent the overall accuracy of disability claims processing at this VARO. However, VARO staff did not accurately process 21 of 52 disability claims (40 percent) reviewed. In OIG's previous report, *Inspection of the VA Regional Office, Manchester, New Hampshire* (Report No. 11-03384-31, November 22, 2011), OIG identified that the most frequent processing errors associated with temporary 100 percent disability evaluations resulted from staff not establishing electronic controls needed to request medical reexaminations to reevaluate the severity of disabilities. During OIG's October 2014 inspection, OIG did not identify similar errors. Therefore, OIG determined the VSC's actions in response to OIG's previous recommendation have been effective. Manchester VARO staff followed VBA's policy for establishing dates of claim in the 30 claims OIG reviewed. However, VARO staff did not correctly process two of seven benefit reduction cases due to other higher workload priorities. OIG recommended the Director review the 111 temporary 100 percent disability evaluations within the universe of claims at the VARO as of August 21, 2014, develop and implement a plan to ensure staff take timely action on reminder notifications for medical reexaminations, and enforce the second signature review policies for TBI and SMC and ancillary benefits rating decisions. The VARO Director concurred with OIG's recommendations and management's planned actions are responsive. OIG will follow up as required. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In March 2015, OIG published six 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 reviews covered the following eleven activities: (1) Quality Management, (2) Medication Management,

(3) Coordination of Care, (4) MRI Safety, (5) Acute Ischemic Stroke Care, (6) Mental Health Residential Rehabilitation Treatment Program, (7) Emergency Airway Management, (8) Follow-Up on Quality Management, (9) Follow-Up on Colorectal Cancer Screening, (10) Environment of Care, and (11) Surgical Complexity.

[VA San Diego HCS, San Diego, California](#)
[West Palm Beach VAMC, West Palm Beach, Florida](#)
[VA Central Western Massachusetts HCS, Leeds, Massachusetts](#)
[VA Roseburg HCS, Roseburg, Oregon](#)
[Ralph H. Johnson VAMC, Charleston, South Carolina](#)
[CAP Summary–Evaluation of Coordination of Care in VHA Facilities](#)

Community Based Outpatient Clinic Reviews

In March 2015, OIG published six 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 three operational activities: (1) Environment of Care, (2) Alcohol Use Disorder, and (3) Human Immunodeficiency Virus Screening.

[CBOC and Outpatient Clinic Reviews San Diego HCS, San Diego, California](#)
[CBOC and Outpatient Clinic Reviews West Palm Beach VAMC, West Palm Beach, Florida](#)
[CBOC and Outpatient Clinic Reviews Central Western Massachusetts HCS, Leeds, Massachusetts](#)
[CBOC and Outpatient Clinic Reviews Ann Arbor HCS, Ann Arbor, Michigan](#)
[CBOC and Outpatient Clinic Reviews Dayton VAMC, Dayton, Ohio](#)
[CBOC and Outpatient Clinic Reviews Martinsburg VAMC, Martinsburg, West Virginia](#)

ADMINISTRATIVE CLOSURES

As a result of a review of OIG decision-making practices on closing reviews administratively, the Deputy Inspector General instituted a new policy requiring coordination of administrative closures within the Immediate Office of the Inspector General, the Office of the Counselor to the Inspector General, and the Release of Information Office. This process will ensure consistency in decision-making regarding when and how public release of related documents is handled. The Deputy Inspector General also directed a retrospective review of administrative closures by the Office of Healthcare Inspections from fiscal year 2014 to present. Based on this review, OIG has begun publishing administrative closure reports on the OIG website, publishing 22 in March. Additional reports will be published pursuant to the Freedom of Information Act as OIG completes the process of reviewing and redacting sensitive information.

[Urology Section Evaluation Delays in Patients with a History of Cancer, Veterans HCS of the Ozarks, Fayetteville, Arkansas](#)
[Alleged Delayed Diagnosis and Treatment, Poor Communication, and Staff Insensitivity, VA Palo Alto HCS, Palo Alto, California](#)

[Alleged Dental Provider Issues at the Pueblo Community Based Outpatient Clinic, VA Eastern Colorado HCS, Denver, Colorado](#)

[Physician Assistant Credentialing, Grand Junction VAMC, Grand Junction, Colorado](#)

[Alleged Nepotism and Preferential Treatment, North Florida/South Georgia Veterans Health System, Gainesville, Florida](#)

[Alleged Quality of Care Issues, North Florida/South Georgia Veterans Health System, Gainesville, Florida](#)

[Patient Safety Issues, West Palm Beach VAMC, West Palm Beach, Florida](#)

[Oversight Review of Facility Response to an Internal Investigation's Findings and Recommendations, VA Northern Indiana HCS, Marion, Indiana](#)

[Mental Health Provider Concerns at the VA Central Iowa HCS, Des Moines Division, Des Moines, Iowa](#)

[Alleged Mismanagement of Care and Lack of Administrative Action, Robert J. Dole VAMC, Wichita, Kansas](#)

[Primary Care Provider Concerns at the Robert J. Dole VAMC, Wichita, Kansas](#)

[Alleged Non-Compliance with VHA Policy, Lexington VAMC, Lexington, Kentucky](#)

[Alleged Inappropriate Opiates Prescribing Practices, Lexington VAMC, Lexington, Kentucky](#)

[Alleged Environment of Care Deficiencies in the Post-Traumatic Stress Disorder Unit VA Central Western Massachusetts HCS, Leeds, Massachusetts](#)

[Review of Surgical Care for Select Patients with Gastrointestinal Surgery, Gulf Coast Veterans HCS, Biloxi, Mississippi](#)

[Follow-Up of Facility Response to Administrative Board of Investigation Findings and Recommendations, Harry S. Truman Memorial Veterans Hospital, Columbia, Missouri](#)

[Suspicious Death, Alleged Premature Discharge, and Quality of Care Issues, VA Southern Nevada HCS, Las Vegas, Nevada](#)

[Alleged Jeopardized Resident Care in the Long Term Care Spinal Cord Injury Unit, Louis Stokes VAMC, Cleveland, Ohio](#)

[Temporary Closure of the Cardiothoracic Surgery Program, Oklahoma VAMC, Oklahoma City, Oklahoma](#)

[Alleged Denial of Treatment of an Actively Suicidal Veteran, Tennessee Valley HCS-Nashville, Nashville, Tennessee](#)

[Colorectal Cancer Screening in 2010, VA Texas Valley Coastal Bend HCS, Harlingen, Texas](#)

[Emergency Department Falsification of Performance Measure Data, Michael E. DeBakey VAMC, Houston, Texas](#)

CRIMINAL INVESTIGATIONS

Former VISN 20 Northwest Network Employee Sentenced for Attempted Murder

A former VISN 20 employee was sentenced to 22 years' incarceration after pleading guilty to attempted murder, stalking, and assault. An OIG, VA Police Service, Federal Bureau of Investigation (FBI), and local sheriff's office investigation determined that the defendant shot her former supervisor, the VISN 20 Chief Financial Officer, twice in the abdomen with a handgun after entering VA office space.

Bribery Charges Involving Palo Alto, California, VAMC Employees and Contractors Result in Judicial Actions

A former Palo Alto, CA, VAMC Contracting Officer Representative (COR) was sentenced to 16 months' incarceration, 3 years' probation, and a \$25,000 fine after pleading guilty to bribery. An OIG and FBI investigation revealed that the defendant accepted approximately \$16,500 in bribes that included cash, airline tickets, and having his credit card bill paid in exchange for ensuring that a VA contractor received continuous work. This defendant, a second VAMC COR, a former VA contracting officer, and a former VA contractor were all charged with multiple offenses to include receipt of a bribe by a public official, bribery of a public official, false statements to a Government agency, conspiracy to commit money laundering, money laundering, and aiding and abetting. In a separate investigation, a VA contractor pled guilty to providing a gratuity to a VA contracting officer. An OIG and FBI investigation revealed that between 2008 and 2011 the contractor paid bribes and gratuities worth approximately \$91,000 to a contracting officer and a COR. The gifts included cash, professional football tickets, Disneyland vacation packages, and a new F-150 truck. In exchange for the gifts, the contractor received VA contracts and task orders worth approximately \$7.5 million.

Durable Medical Equipment Vendor Sentenced for Kickbacks

A Durable Medical Equipment (DME) vendor, who cooperated with the Government, was sentenced to 120 days' home confinement and 2 years' probation. An OIG investigation revealed that the defendant paid more than \$71,000 in kickbacks to the former West Palm Beach, FL, VAMC Chief of Prosthetics and conspired with that employee to create fraudulent DME orders, which were never provided to veterans. For

over 4 years the defendant cultivated relationships within the Prosthetics Service to obtain over \$2.2 million in DME orders. Additionally, the defendant conspired with the VA employee to create an orthotic shoe fitting business, in which they agreed to split the profits. The loss to VA is approximately \$143,019 for the fraudulent DME orders and \$671,730 in overcharges for DME.

Former Northport, New York, VAMC Information Technology Specialist Sentenced for Illicit Salary Supplementation

A former Northport, NY, VAMC IT Specialist was sentenced to 1 year of probation and ordered to pay a \$250 fine after pleading guilty to illicit salary supplementation. An OIG investigation revealed that the defendant unlawfully accepted over \$40,000 in gifts, to include expense-paid vacations, dinners, golf outings, and concert tickets from sales representatives working for a telecommunications firm contracted by the medical center. The gifts were paid to the defendant because of a long standing relationship he developed with the contractor and not for any specific act.

Birmingham, Alabama, VAMC Union President Arrested for Embezzlement

A Birmingham, AL, VAMC employee, who served as president of the American Federation of Government Employees (AFGE) union, was indicted and arrested for bank fraud and other charges. A VA OIG, Department of Labor (DOL) OIG, and DOL Office of Labor-Management Standards investigation revealed that the defendant embezzled more than \$132,000 from the local AFGE chapter.

Defendant and Contractor Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

A VA contractor was sentenced to 2 years' probation, with up to 180 days in a residential reentry program, and a contracting firm was sentenced to 2 years' probation. Both contractors were also ordered to forfeit \$3,352,510 (jointly) after pleading guilty to major program fraud. A VA OIG, General Services Administration OIG, Small Business Administration OIG, Defense Criminal Investigative Service, and Federal Deposit Insurance Corporation OIG investigation revealed that the defendant and another contractor secured approximately \$23.5 million in Service-Disabled Veteran-Owned Small Business (SDVOSB) set-aside and sole-source contracts under the guise of a legitimate SDVOSB business when the business was actually a pass-through company.

Former VA Fiduciary Arrested for Theft and Misappropriation

A former VA fiduciary was arrested for theft of Government funds and misappropriation by a Federal fiduciary. An OIG investigation revealed that for over 5 years the defendant stole approximately \$141,000 from 22 veterans, using excessive "fiduciary fees" and her sham company to justify the excessive expenses.

VA Contractor Ordered To Pay Restitution

A VA contractor was ordered to pay \$108,199,452 in restitution. The defendant was previously sentenced to 20 years' incarceration and 3 years' supervised release after pleading guilty to wire fraud. An OIG investigation revealed that the defendant, who had a contract to supply latex gloves to VA, accepted more than \$150 million from investors

who believed they were financing his VA contracts. In reality, sales to VA were only about \$25,000 per year. The defendant admitted to operating a large-scale Ponzi scheme, falsifying VA documents, and instructing his employees to impersonate VA officials. The Government is also pursuing forfeiture of 11 real properties in which the defendant has a partial ownership interest; 2 apartment buildings; 2 vehicles; and the cash value and proceeds from 20 bank accounts, 3 insurance policies, numerous seized checks, and money orders. The Government is also pursuing any tax liabilities that may be owed by the defendant.

Washington, DC, VAMC Employee Arrested for Threats of Bodily Harm

A Washington, DC, VAMC employee was arrested for threatening to bring weapons into the medical center and "become an emerging threat."

Former Hampton, Virginia, VAMC Registered Nurse Arrested for Abusive Sexual Contact

A former Hampton, VA, VAMC registered nurse was arrested for abusive sexual contact. An OIG investigation revealed that while working in the emergency department the defendant sexually assaulted a patient.

University of California, Los Angeles, Anesthesiologist Charged with Theft of Government Property and Simple Possession

A University of California, Los Angeles (UCLA), anesthesiologist was charged with theft of Government property and simple possession of a controlled substance. A multi-agency investigation revealed that while completing a rotation at the West Los Angeles, CA, VAMC and providing anesthesia care to a veteran in surgery, the defendant collapsed due to sublingual ingestion of clonazepam and injection of multiple controlled substances.

Gainesville, Florida, VAMC RN Arrested for Fraudulently Acquiring Controlled Substances

A Gainesville, FL, VAMC RN was arrested for fraudulently acquiring controlled substances. An OIG investigation revealed that on multiple occasions the defendant removed meperidine and fentanyl from VA Pyxis machines and then used the diverted narcotics.

Former VA Physician and a Veteran Arrested for Obtaining a Controlled Substance by Fraud

A former VA physician and a veteran were arrested for obtaining a controlled substance by fraud. An OIG and local police investigation revealed that the VA doctor treated the veteran for a period of time while a legitimate provider/patient relationship existed. However, the provider/patient relationship became personal, and after leaving VA employment the doctor continued to prescribe controlled medications to the veteran using VA prescriptions. Both the doctor and the veteran received pills from the prescriptions that were filled at outside pharmacies. The doctor surrendered her medical license as a result of this investigation.

Contract Employee Pleads Guilty to Identity Theft Involving Tampa, Florida, VAMC Medical Records

A former employee of a company contracted by the Tampa, FL, VAMC to shred sensitive documents pled guilty to access device fraud and aggravated identity theft. A multi-agency investigation revealed that the defendant stole medical records containing veterans' personal identifying 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.

Defendant Sentenced for Identity Theft

A defendant was sentenced to 51 months' incarceration and 3 years' supervised release. An OIG, Internal Revenue Service Task Force, and FBI investigation revealed that the defendant used a veteran's identity that she obtained from a Kaplan University employee who oversaw VA education benefits. During the investigation, undercover law enforcement personnel purchased VA and Kaplan documents containing identity information for 195 veterans who either attended or applied to Kaplan University and later seized similar documents for another 147 veterans during the execution of a search warrant.

Veteran Involuntarily Committed after Making Threats Against a VA Employee and President Obama

A veteran was involuntarily committed after making threats against a St. Petersburg, FL, VARO employee and President Obama. An OIG, U.S. Secret Service, and VA Police Service investigation revealed that the veteran threatened the VARO employee and demanded \$90,000 from VA so that he could buy guns and ammunition to blow up the world in order to achieve world peace. During an interview, the veteran also threatened President Obama and Members of Congress.

Veteran Arrested for Communicating Threats

A veteran was arrested for communicating threats. After the initial threat, the veteran was banned from receiving treatment at a CBOC and was required to receive treatment at the Asheville, NC, VAMC. During the following 3 weeks, the veteran threatened to kill herself and VA staff, including her doctor, on two additional occasions. The defendant visited the VAMC without checking in with VA Police Service as required and refused a consent search of her belongings. It was also confirmed that the defendant had obtained a handgun permit.

Veteran Arrested for Threats to a Buffalo, New York, VAMC Employee

A veteran was sentenced to time served (19 months), 2 years' supervised release, and additional psychiatric treatment after pleading guilty to possession of a firearm by someone adjudicated as mentally ill or who has been committed to a mental institution. An OIG investigation was initiated after the defendant made threats regarding a Buffalo, NY, VAMC employee and was then found to be in possession of weapons and ammunition even though he was a convicted felon.

Veteran Sentenced for “Stolen Valor” Fraud

A veteran was sentenced to 24 months’ incarceration, 3 years’ supervised probation, and ordered to pay VA restitution of \$503,298 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant, a retired state trooper, 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 (PTSD). The investigation also revealed that the defendant was “doctor shopping” from approximately January 2010 to August 2012.

Veteran and Spouse Arrested for Compensation Fraud

A veteran and his spouse were arrested for wire fraud, mail fraud, and conspiracy for fraudulently receiving VA and Workers’ Compensation benefits. A VA OIG, United States Postal Service (USPS) OIG, and DOL OIG investigation revealed that, although the veteran claimed to be paralyzed, he was observed walking, riding a bike, and cutting trees with a chain saw. The defendant only utilized a wheelchair when attending his VA medical appointments and a cane when attending his USPS and DOL exams. The veteran’s wife is accused of assisting her husband with his deception. The loss to VA is approximately \$700,000, and the loss to the USPS is approximately \$300,000.

Widow of Deceased Veteran Sentenced for VA Compensation Fraud

The widow of a deceased veteran was sentenced to 14 months’ probation, 8 months’ home detention, ordered to pay \$62,142 in restitution, and undergo mental health treatment. An OIG investigation determined that the defendant failed to notify VA of her February 2007 remarriage and continued to receive Dependency and Indemnity Compensation she was no longer entitled to receive.

Veteran Pleads Guilty To Making False Statements

A veteran pled guilty to making false statements in connection with VA compensation claims that he submitted to a VARO. An OIG investigation revealed that the defendant submitted more than 90 fraudulent forms for 21 different veterans without their knowledge or consent. The defendant forged each veteran’s signature and falsely stated that each veteran suffered from various medical conditions.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated 41 VA benefit checks and stole VA funds from 14 direct deposits that were issued after her mother’s death in October 2009. The defendant also admitted to forging and submitting a Marital Status Questionnaire to VA to make it appear her mother was still alive in order to continue to receive the VA benefits. The loss to VA is \$78,939.

Widower of a Deceased VA Beneficiary Sentenced for Theft

The widower of a deceased VA beneficiary was sentenced to 5 months’ incarceration, 5 months’ home confinement, 36 months’ probation, and ordered to pay VA restitution of \$75,815 after pleading guilty to theft of public funds. An OIG investigation revealed

that the defendant stole VA funds that were direct deposited to a joint account after his wife's death in July 2004 and used the money for personal expenses.

Veteran Arrested for Theft of Government Funds

A veteran was arrested for theft of Government funds. An OIG and Social Security Administration (SSA) investigation revealed that the defendant filed fraudulent VA and SSA documents reporting that his 103-year-old mother was still alive. Following the execution of multiple search warrants, agents learned that the defendant likely disposed of his mother's body in an unmarked grave in the 1980's; however, her remains have not yet been located. The loss to VA is approximately \$370,000, and the loss to SSA is approximately \$114,000.

Business Owner Arrested for Theft of VA Funds

A business owner was sentenced to 5 months' incarceration, 3 years' probation, and ordered to pay VA \$116,000 in restitution. 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.

Widow Arrested for Theft and False Statements

A widow was arrested for theft of Government funds and false statements after an OIG investigation determined that the defendant, while receiving widow's pension benefits, failed to report her re-marriage and provided false statements to VA in order to continue to fraudulently receive the benefits. The loss to VA is \$55,894.

Non-Veteran Arrested for Healthcare Fraud

A non-veteran was indicted and subsequently arrested for health care fraud. The defendant falsely claimed to have served in the Army National Guard from 1996 to 2010, to suffer from PTSD, and to have served in combat during two tours in Afghanistan. An OIG investigation revealed that the defendant never served in the military and was incarcerated during the same time period that she claimed to have been in the military. For over 2 years, the defendant received over \$20,000 in VA health care benefits in addition to non-VA care paid by VA. The defendant also received more than 10,000 milligrams of oxycodone from VA. During the investigation, the defendant fled to New Mexico, where she was apprehended by the U.S. Marshals Service.

Non-Veteran Sentenced for Healthcare Fraud

A Roseburg, OR, VAMC outpatient was sentenced to 60 months' probation after pleading guilty to health care fraud. An OIG investigation determined that the defendant fraudulently received travel benefits, Department of Housing and Urban Development and VA's Supportive Housing, 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 until 2012. The loss to VA is approximately \$32,000.

Veteran Charged With “Doctor Shopping”

A veteran was charged with 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 approximately 2 years the defendant obtained 10,792 pills of Schedule II Controlled Substances from both VA and non-VA providers.

Postal Service Manager Pleads Guilty to Theft of Mail

A Postal Service manager pled guilty to theft of mail by an officer or employee. A VA OIG, Postal Inspection Service, and Postal OIG investigation revealed that the defendant stole a large number of controlled VA pharmaceuticals intended for veterans in both Kentucky and Indiana. A search warrant was executed during the investigation resulting in the recovery of approximately 2,000 pills and numerous VA pills bottles. The loss to VA exceeds \$2,000.

Five Veterans Sentenced for Travel Benefit Fraud

Five veterans were sentenced to various periods of incarceration, supervised release, and ordered to pay VA restitution of between \$1,187 and \$7,594 after pleading guilty to theft of public money. An OIG and VA Police Service investigation revealed that the defendants submitted fraudulent travel vouchers to the Mountain Home, TN, VAMC claiming an inflated distance of travel.

Veteran Indicted for Travel Benefit Fraud

A veteran was indicted for false statements and theft. An OIG investigation determined that the defendant submitted false travel reimbursement claims indicating that he traveled in excess of 4 hours to the Detroit, MI, VAMC for appointments. The loss to VA is \$33,000.

Veteran Sentenced for Travel Benefit Fraud

A veteran was sentenced to 60 days' incarceration, 3 years' supervised release, and ordered to pay restitution of \$20,147. An OIG investigation revealed that the defendant received beneficiary travel pay based on travel from a fraudulent address in Kentucky to the Marion, IL, VAMC. The investigation further determined that the defendant resided in Marion, IL. The loss to VA is \$20,147.

Fugitive Felon VA Employee Arrested With Assistance of OIG

OIG and VA Police Service assisted a local police department with arresting a fugitive VA employee at the Mountain Home, TN, VAMC. The fugitive was wanted on an outstanding warrant for accessory after the fact to murder.

Fugitive Veteran Arrested With Assistance of OIG

A veteran was arrested at the Manhattan, NY, VAMC by a U.S. Marshals Service Regional Task Force with the assistance of OIG. The fugitive was wanted for charges to include indecent and aggravated assault. The fugitive is alleged to have lured a

female minor to a hotel room in Pennsylvania where he tied her to a bed, sexually assaulted her, and then struck her in the head several times with a mallet.

A handwritten signature in black ink, appearing to read "Richard J. Griffin". The signature is written in a cursive, flowing style.

Richard J. Griffin
Deputy Inspector General