



Department of Veterans Affairs

Office of Inspector General

August 2016 Highlights

ADMINISTRATIVE INVESTIGATIONS

Misuse of Official Time, Denver VA Regional Office, Denver, Colorado

The Chairman of the House Committee on Veterans' Affairs, after receiving a complaint letter, asked VA's OIG to investigate allegations that the Director of the Denver VA Regional Office was habitually absent from work during her designated duty hours and submitted incorrect timecards. OIG substantiated that she misused her official time when she arrived to her duty station late without taking the appropriate leave; when she was absent without leave; and when she improperly split her workday between her duty station, a non-VA location, and teleworking from home. OIG also found that she maintained an improper credit hour system for herself and her office staff. OIG did not substantiate an allegation that she was absent for several weeks at a time without taking sick leave, and OIG administratively closed that allegation. OIG discovered that VA's Office of Accountability Review (OAR) began an investigation concurrent to OIG's. To avoid any duplicative efforts, OIG accepted the misuse of time and timecard allegations, and OAR accepted all other allegations for investigation.

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

OIG REPORTS

Audit of VA's Green Management Program Solar Panel Projects

Senator John Boozman and Congressman French Hill of Arkansas requested that OIG conduct a review of an \$8 million, 1.8 million megawatt work-in-progress solar panel system at the John L. McClellan Memorial Veterans Hospital, Little Rock, AR. OIG's objective was to determine whether VA effectively planned and managed its work-in-progress solar photovoltaic projects to meet project timelines and expected project power generation goals. OIG found that the Little Rock VA medical facility did not effectively plan the installation of a solar panel system. The project experienced significant delays and additional contract costs due to disassembly of previously installed solar panel carport structures to accommodate a parking garage. As a result, the solar project is expected to be fully completed in January 2017, over 4 years beyond its original completion date, with unexpected costs of approximately \$1.5 million. OIG also reviewed 11 of 15 solar projects awarded from fiscal year (FY) 2010 through FY 2013 that were a work-in-progress as of May 2015. At the completion of OIG's audit work in March 2016, only 2 of 11 solar projects were fully completed. In July 2016, VA informed OIG that 5 of 11 solar projects were fully completed. These delays occurred because of planning errors, design changes, a lengthy interconnection process, and contractor delays. As a result, VA did not increase renewable energy for those solar projects in the time frame planned and incurred additional costs through needed contract modifications. OIG recommended the Interim Assistant Secretary for Management implement additional controls to prevent solar panel conflicts, share best practices for executing timely interconnection agreements, implement power generation monitoring controls, and conduct lessons learned assessments.

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

Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma

At the request of former Senator Tom Coburn and an anonymous complainant, OIG conducted a review to evaluate the alleged closure of the Cardiothoracic (CT) Surgery program and assess Cardiac Catheterization Laboratory (CCL) medication administration and Omnicell® medication dispensing system access issues at the Oklahoma City VA Health Care System (HCS), Oklahoma City, OK. OIG did not substantiate that the HCS closed the CT surgery program. Rather, HCS leadership paused CT surgeries in order to evaluate the program following patient deaths. OIG did not substantiate the allegation that CCL nurses administered medications to patients in the CCL without a physician's order or that the two patients OIG reviewed suffered harm related to CCL medication administration practices. OIG could not substantiate that a nurse manager had staff passwords to the Omnicell® and could use the passwords to access and remove medications under another nurse's account. In response to additional requests from Senator James Inhofe, OIG is continuing work to evaluate the HCS's quality management program, analyze data from VA's Strategic Analytics for Improvement and Learning (SAIL) Value Model report, and follow up on the results of an Employee Assessment Review (EAR) survey. OIG's results from this review will be addressed in a future report. OIG made no recommendations.

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

Review of Primary Care Ghost Panels, Veterans Integrated Service Network 23, Eagan, Minnesota

OIG conducted an inspection in response to allegations received by Congressman Timothy J. Walz regarding whether some primary care (PC) panels at facilities within Veterans Integrated Service Network (VISN) 23 were ghost panels. The term "ghost panel" is VA wording used to describe patients assigned to PC providers who were not actively providing care, such as a provider who retired or resigned. OIG found that 4 of 674 (0.6 percent) PC panels in VISN 23 were ghost panels. In total, 2,301 of 287,095 (0.8 percent) of active PC patients in VISN 23 were assigned to one of those panels. The Iowa City VA HCS and VA Black Hills HCS each had two ghost panels. OIG did not identify PC ghost panels at the other VISN 23 facilities. The existence of PC ghost panels in VISN 23 is inconsistent with Veterans Health Administration (VHA) policy, which requires patients to be reassigned or redistributed to other PC teams when PC providers discontinue employment. However, OIG did not identify a negative impact on patients since the facilities had enacted efforts to ensure ongoing patient care for patients assigned to the PC ghost panels. OIG recommended that the VISN 23 Acting Director ensure that facility Directors reassign or redistribute PC patients to other PC teams as required by VHA and monitor compliance. [\[Click here to access report.\]](#)

Reported Primary Care Staffing at St. Cloud VA HCS, VISN 23, Eagan, Minnesota

OIG conducted an inspection to assess allegations made regarding a September 14, 2015 letter from the VISN 23 Acting Director to Congressman Timothy J. Walz concerning primary care at the St. Cloud VA HCS, St. Cloud, MN. While OIG substantiated that part of the VISN 23 response did not accurately represent HCS gains and losses of physicians and mid-level providers, it appeared to be an inadvertent error.

OIG substantiated that the VISN 23 response inaccurately represented primary care provider panel sizes at the HCS. The reported average primary care panel size was based upon a simple average of panel sizes across all HCS providers and did not include adjustment for factors such as whether the provider was a part-time employee. OIG found that most primary care providers had panel sizes outside VHA expected panel sizes range, which affects the timeliness of patients seeing a provider. OIG also reviewed the accuracy of data provided in a response from the VISN to the OIG Hotline Case at issue. OIG found that the HCS-reported average panel size for November 2013 was generally accurate compared to the historical Primary Care Management Module data for November 2013. [\[Click here to access report.\]](#)

Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA HCS, Minneapolis, Minnesota

OIG conducted an inspection in response to allegations received by Congressman Timothy J. Walz concerning the Psychiatry Partial Hospitalization program and management concerns at the Minneapolis VA HCS, Minneapolis, MN. OIG did not substantiate the allegation that patients in the Psychiatry Partial Hospitalization program who were diagnosed in the community, military, or through the compensation and pension process with mental health, substance use, or post-traumatic stress disorder diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong. Since the complainant was anonymous, OIG was unable to clarify the allegation or identify specific patients or services that may have been the subject(s) of the complaint. OIG could not substantiate the allegation that psychologists were performing inappropriate psychological testing on patients in the Psychiatry Partial Hospitalization program to meet productivity numbers. OIG could not substantiate the allegation that supervisory staff were absent in their leadership roles and were not trained in the areas they supervised. [\[Click here to access report.\]](#)

Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan

In January 2016, OIG received an allegation that the VA Medical Center (VAMC) in Detroit, MI, purchased 300 televisions (TVs) and accessories in September 2013 for about \$311,000. The complainant alleged the facility never installed the TVs because they were the wrong type. OIG substantiated the allegation the Detroit VAMC had not installed and used 282 of the 300 TVs or associated accessories it had purchased. The facility acquired the equipment in September 2013 as part of a project to replace the patient TV system in the facility, but as of April 2016, 282 of the TVs and associated accessories were not in use. The facility was unable to install the items in the patient rooms because the items did not meet the design specifications identified in the patient TV system architect and engineer (AE) services contract. OIG determined Detroit VAMC officials did not communicate with the AE contractor in a timely manner to ensure the TVs purchased were compatible with the project design and specifications. Thus, the Detroit VAMC issued a contract modification for \$19,052 to adjust the project design and specifications to support the TVs purchased. The TVs and related accessories should have been purchased closer to award of the construction contract. By purchasing these items well before a construction contract to install them was awarded,

the facility exposed itself to unnecessary financial risk in the event it did not proceed with the project, and the facility also allowed valuable warranties to expire, increasing the risk of incurring additional expenses to replace any faulty TVs. OIG recommended the VISN 10 Acting Director strengthen policy to ensure the proper equipment is purchased at the appropriate time, as well as develop and implement a plan to use the purchased TVs. OIG also recommended the VISN 10 Acting Director determine whether a bona fide needs violation occurred, and take appropriate corrective action if required. [\[Click here to access report.\]](#)

Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System

On June 4, 2015, OIG received an allegation that VA acquisition personnel mismanaged the award of the ambulette services task orders at the New York Harbor Healthcare System (NYHHS). There was also an allegation of contract steering for the re-solicited requirement. OIG's review focused on determining the merit of the allegations. OIG substantiated the allegation that VHA acquisition personnel mismanaged the award of the ambulette services at NYHHS because they improperly awarded two task orders for ambulette services when the contractor's Federal Supply Schedule contract did not offer these services. In addition, the contracting officer's award determination for the re-solicited requirement was not clearly justified. Further, acquisition personnel did not document pertinent contracting actions in VA's Electronic Contract Management System (eCMS). However, OIG did not substantiate the allegation of contract steering for the re-solicited requirement. The award mismanagement occurred because VA's Integrated Oversight Process (IOP) reviews, designed to improve contract quality, were either not completed or not documented for the two task orders valued at \$20 million. If performed, these reviews may have revealed the contractor did not offer ambulette services. Further, personnel turnover caused confusion as to who should ensure contract documentation was included in eCMS. As a result, acquisition personnel put VA at risk for protests and payment to protesters for restitution. OIG recommended the Under Secretary for Health implement an oversight process to ensure IOP reviews are completed. OIG recommended the Head of Contracting Activity, VHA, Service Area Office (SAO) East, develop a mechanism to ensure effective coordination between acquisition personnel when transferring contracting responsibilities and implement a process to ensure eCMS is used to record contracting actions. OIG considered the plans acceptable.

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

Diagnosis and Treatment of a Patient's Adrenal Insufficiency at a Virginia VAMC

OIG conducted a review to assess allegations of misdiagnosis of Addison's disease and adverse outcomes resulting from long-term steroid treatment in a patient with multiple medical problems. OIG substantiated that the patient's electronic health record problem list first reflected the patient had Addison's disease in 2004, although laboratory tests did not support this diagnosis. The patient received steroid medications after developing signs and symptoms of adrenal insufficiency in 2004. Because steroid medication was the appropriate treatment option for adrenal insufficiency that was caused by either Addison's disease or another disease process, the patient received

appropriate care at the time the steroids were initially started. Between 2004 and 2006, VA providers were not able to assure routine follow-up of the patient's condition due to irregular use of health care services. When the patient re-established routine care with a VA primary care provider in 2007, actions should have been taken to reassess the patient and confirm the adrenal disease-related diagnosis. Ultimately, a comprehensive evaluation of the patient's medical history, co-occurring conditions, laboratory and imaging tests, and medication actions and interactions was completed in 2012 and an endocrinologist was able to wean the patient off chronic steroid therapy. OIG could not substantiate the allegation that the patient experienced adverse health events including avascular necrosis of the hip joints solely as a result of prolonged steroid treatment for adrenal insufficiency. The patient had a complex medical history, and OIG believes the most likely cause of the avascular necrosis and need for bilateral hip replacement was a combination of long-term steroid use and the various treatments used to manage his other comorbidities. [\[Click here to access report.\]](#)

Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas HCS, Dallas, Texas

OIG conducted a review to determine if system leadership took appropriate administrative actions in response to reports of deaths and quality of care irregularities at the Dallas VAMC, part of the VA North Texas HCS. OIG substantiated that in 2012, a patient died after sustaining head trauma from a fall in the Radiology Department. OIG found HCS leadership had investigated the incident and disclosed the fall to the patient's family. OIG identified quality of care concerns related to the timely completion and interpretation of imaging study results for the patient. OIG substantiated that in 2011, a patient died following baptism in a VAMC pool. OIG found the HCS conducted a review of the incident. However, OIG found HCS leadership did not follow up on an ethics consultation recommendation that the VAMC consider revising its "Do Not Resuscitate" policy to include re-addressing the status of "Do Not Resuscitate" orders with patients prior to any hospital procedures. OIG substantiated that in 2012, a VAMC employee died of an overdose and a patient died of a self-inflicted gunshot wound in facility restrooms. Related to the overdose death, OIG found HCS leadership did not improve employee drug testing procedures. OIG substantiated that in 2013, an employee was injured during transport of a patient undergoing cardiopulmonary resuscitative effort. OIG did not substantiate that the patient being resuscitated fell from a gurney during the resuscitative efforts. OIG found HCS leadership was apprised of these events, had conducted internal reviews, and taken appropriate actions. OIG did not substantiate poor wound care during the site visit. Nevertheless, in 2012, HCS staff identified an increase in pressure ulcer prevalence and implemented several new initiatives with positive outcomes. OIG also found no evidence that licensed vocational nurses were administering intravenous medications. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

Former VA Contractor Sentenced for Wire Fraud

A former VA contractor was sentenced to one year of home confinement, three years' supervised release, and was ordered to pay \$169,677 in restitution after pleading guilty to wire fraud. An OIG investigation resulted in the contractor and a VA employee being

charged with conspiring to order goods and services that were not needed and were never provided to the West Roxbury, MA, VAMC. For approximately two years, the VA employee, who was responsible for the maintenance and information technology support of medical equipment, created the false purchase orders and then paid the contractor using his VA purchase card. The investigation determined that VA paid the contractor and his company a total of \$222,242 for over 82 purchases. The employee and contractor then divided the fraudulently obtained payments. The VA employee died after being charged.

Veteran and Others Indicted for Procurement Fraud

A veteran was one of seven individuals and two corporations indicted for procurement fraud related to the award of nearly \$350 million in Federal Government construction contracts. The indicted veteran claimed to control and operate an SDVOSB, and other defendants claimed to control and operate minority-owned and woman-owned businesses in order to obtain Government set-aside contracts. However, a multi-agency investigation resulted in the defendants being charged with hiding the fact that construction companies that actually performed the work were not controlled by disabled veterans, minorities, or women.

Six Subjects Indicted for Wire Fraud

Six subjects have been indicted and three pled guilty to various charges to include conspiracy to defraud the United States, major fraud against the United States, and wire fraud. A multi-agency investigation revealed that a fraudulent SDVOSB construction company contracted with VA to build a 400-space parking structure at the Durham, NC, VAMC. When the contractor defaulted on the project after completing about 70 percent of the work, VA attempted to activate the performance and payment bonds to compensate subcontractors and suppliers and to complete the project. The company is alleged to have purchased fake bonds because they lacked the working capital to purchase legitimate bonds. The fraudulent companies were found to have been conducting fraudulent bonding business for at least 10 years and had significantly impacted both state and Federal contracts. The total amount of the bonds was approximately \$11 million, including \$6.5 million for VA projects. The fraudulent company also had Cease and Desist Orders issued against them in at least seven states.

Veteran Found Guilty of Surety Bond Fraud

A veteran was found guilty at trial of major fraud against the Government, mail fraud, and false statements. A multi-agency investigation resulted in the discovery of an extensive Surety Bond fraud scheme that affected multiple Federal agencies and over \$935 million in Government construction contracts. The defendant, along with other co-conspirators, was charged with using Government-owned lands or bogus Trusts as assets to back Bid, Payment, and Performance bonds while accepting approximately \$10 million in bonding fees. For two years, the defendant received over \$400,000 in bonding fees alone. The impacted VA contracts totaled more than \$97 million, including some American Reinvestment and Recovery funds.

Mortgage Company President Arrested for Conspiracy and Wire Fraud

The president and founder of a now-defunct mortgage company, Mortgage Security, Inc. (MSI), was indicted and arrested for conspiracy and wire fraud. The charges were the result of a VA OIG, Housing and Urban Development OIG, Department of Agriculture OIG, and Federal Bureau of Investigation (FBI) investigation involving the defendant's alleged scheme to defraud Ginnie Mae, a Government-run corporation. MSI was contracted with Ginnie Mae to pool eligible residential mortgage loans and then sell Ginnie Mae-backed mortgage bonds to investors. MSI was responsible for servicing the loans in the pools it created, including collecting principal and interest payments from borrowers, as well as loan payoffs, and placing those funds into accounts held in trust by Ginnie Mae. Among other things, Ginnie Mae required issuers, like MSI, to provide regular reports to Ginnie Mae concerning the status of the loans in the pools. Beginning in 2011, the defendant allegedly began diverting money that borrowers were sending to MSI in order to pay off several Federal Housing Administration and two VA loans. Specifically, the defendant is alleged to have deposited large-dollar loan-payoff checks into secret accounts and then used those funds for personal and business uses. The defendant allegedly stole nearly \$3 million, which Ginnie Mae then had to reimburse to the guaranteed investors.

Former VA Fiduciary Arrested for Embezzlement

A former VA fiduciary was indicted and arrested for wire fraud, misappropriation by a Federal fiduciary, making false statements, and preparing fraudulent tax returns. An OIG, FBI, and Internal Revenue Service (IRS) Criminal Investigation Division (CID) investigation determined that from 2007 to 2012 the defendant served as a VA fiduciary for eight disabled veterans and allegedly embezzled VA-issued funds. The defendant allegedly used the stolen funds to pay down the mortgage on his house. The total embezzlement amount is still being determined.

Settlement Agreement Reached Between Remington College and a United States Attorney's Office

A settlement agreement was reached between Remington College and the United States Attorney's Office, District of Hawaii, after the college agreed to pay \$295,000 to resolve alleged False Claims Act violations. The agreement was the result of an OIG investigation that alleged that Remington College submitted false statements and false claims in order to obtain educational benefit payments from VA for beneficiaries who were enrolled in an unapproved program.

Majority Owner of New England Compounding Center and Husband Plead Guilty to Structuring Cash Withdrawals

The majority owner of New England Compounding Center (NECC) and her husband pled guilty to structuring cash withdrawals after learning that NECC was the subject of a Federal investigation. The defendants admitted to making structured withdrawals totaling approximately \$124,000 following the initiation of an OIG, FBI, Food and Drug Administration (FDA), United States Postal Inspection Service (USPIS), and Defense Criminal Investigative Service (DCIS) investigation that alleged that NECC products caused the deaths of 64 people and caused fungal infections in approximately

700 others. Although no known VA patients died or became ill as a result of receiving a NECC product, VA did purchase approximately \$516,000 of products from NECC, all of which were allegedly produced in unsanitary conditions and in an unsafe manner. Neither defendant had an active role in the operations or management of NECC.

Veteran's Son Sentenced for Identity Theft

The son of a service-disabled veteran was sentenced to 69 months' incarceration and 36 months' supervised release after previously being found guilty at trial of theft and aggravated identify theft. No restitution was ordered due to services being provided; however, a Notice of Intent to Seek Criminal Forfeiture requesting interest in \$1,270,304 was filed. A VA OIG, Army CID, DCIS, General Services Administration (GSA) OIG, and Social Security Administration (SSA) OIG investigation resulted in the defendant being charged with using his father's identity and military history to create two SDVOSB companies. The defendant fraudulently certified both businesses as SDVOSBs and subsequently obtained 15 SDVOSB set-aside contracts. The service-disabled veteran was not aware that his identity was used and was not involved with either business. The loss to the Federal Government is \$2.7 million, which includes a loss to VA of \$1.2 million.

Veteran Arrested for Larceny

A veteran was arrested for larceny. An OIG, IRS CID, and state police investigation resulted in the defendant being charged with fraudulently taking payments from several veterans with the promise of getting the veterans VA compensation and Social Security benefits. The defendant allegedly told his victims their payments would be used to pay an attorney to do research and file their claims with VA and/or SSA. The defendant allegedly took over \$500,000 from his victims and never filed a single claim on their behalf.

Veteran and Wife Indicted for VA Compensation Fraud

A veteran and his wife were indicted for fraud following an OIG investigation of allegations that the veteran provided VA with false information regarding his vision loss. The veteran had been rated with a 100 percent service-connected disability rating for blindness; however, the veteran was able to drive, shoot firearms, and perform most functions of daily living without the assistance of another person or low vision aids. The veteran received approximately \$311,000 in VA compensation payments.

Veteran Indicted for Fraud Involving VA Programs

A veteran was indicted for false, fictitious or fraudulent claims, theft of Government funds, false statements relating to health care matters, and health care fraud. The defendant allegedly manufactured a fraudulent DD-214 claiming a Purple Heart, Special Forces service, and combat service in Vietnam. The defendant was subsequently awarded 100 percent service-connected disability for post-traumatic stress disorder and as a result, fraudulently received VA compensation benefits, health care benefits, education benefits, and travel reimbursement benefits. In fact, the defendant received an "Other than Honorable" discharge for being absent without leave and he never served in combat. The loss to VA is \$137,240.

Veteran Sentenced for Fraud

A veteran was sentenced to 25 years' incarceration, three years' supervised release, and was ordered to pay \$2,316,862 in restitution (\$79,362 to VA) after previously being found guilty at trial of conspiracy to commit wire fraud, wire fraud, false claims, theft of public funds, fictitious obligation, false statements, and failure to file a tax return. An OIG and IRS CID investigation resulted in the defendant being charged with orchestrating a large-scale Nigerian oil investment scheme that defrauded investors of over \$2 million. While perpetrating the investment scheme, the veteran fraudulently received individual unemployability compensation benefits from VA.

Daughter of Deceased VA Beneficiary Sentenced for Theft

The daughter of a deceased VA beneficiary was sentenced to five years' probation and was ordered to pay VA restitution of \$95,658. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after her mother's death in May 2008. The defendant admitted to using the VA funds for personal expenses.

Former Daughter-in-Law of Deceased VA Beneficiary Indicted for Theft

The former daughter-in-law of a deceased VA beneficiary, who was the Power of Attorney, was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefit checks and direct deposits that were issued after the beneficiary's death in November 2005. The defendant is alleged to have used the stolen funds for personal expenses. The loss to VA is \$89,868.

Neighbor of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The neighbor of a deceased VA beneficiary pled guilty to theft of Government funds. The defendant had been assisting his neighbor, a VA beneficiary, before her death and had access to her checkbook. The defendant allegedly wrote 70 checks to himself from the beneficiary's account after her death in December 2009, forging her signature on each check. The loss to VA is \$79,958.

VA Loan Guaranty Program Beneficiary Pleads Guilty to Making a False Statement To Obtain a Loan

A VA loan guaranty program beneficiary pled guilty to making a false statement to obtain a loan. A VA OIG, USPIA, SSA OIG, and local police investigation resulted in the defendant being charged with using allegedly falsified information (including employment and income information) to obtain a \$423,000 home loan guaranteed by VA. The defendant subsequently defaulted on the home loan. The defendant was also alleged to have provided false information to obtain a vehicle loan, and then manufactured a scheme to remove the first lien from the vehicle title in order to resell the vehicle for \$55,000 to a legitimate second vehicle dealer.

Veteran Sentenced for Assault on a Federal Officer

A veteran was sentenced to three years' probation after pleading guilty to assault on a Federal officer. The defendant has a history of assaulting VA police officers and this

was his second assault conviction involving VA. During the most recent incident at the East Orange, NJ, VAMC, the defendant was charged with assaulting several VA police officers resulting in injuries to two officers.

Veteran Indicted for Making Threats to the Albany, New York, VAMC

A veteran was indicted for making threats to commit a mass shooting at the Albany, NY, VAMC. The defendant allegedly made phone calls to the medical center threatening to “kill everybody” and go to the VAMC “with [his] Uzi and start shooting people up.” The defendant is being held pending further judicial action. The defendant was previously arrested in 2015 for making similar threats to the Canandaigua, NY, VAMC.

Veteran Sentenced After Pleading Guilty to Threatening a Federal Official

A veteran was sentenced to time served and three years’ probation after pleading guilty to threatening a Federal official. An OIG and VA Police Service investigation resulted in the defendant being charged with threatening to assault the White River Junction, VT, VAMC chief of staff and his family. The judge ordered additional supervised release terms, to include no contact with the victims in this case, participating in a mental health program, and submitting to the search of his person and property upon reasonable suspicion that the defendant has violated a condition of supervision.

Little Rock, Arkansas, VAMC Pharmacy Technician Arrested for Drug Diversion

A Little Rock, AR, VAMC pharmacy technician was arrested for theft of Government property, possession with intent to distribute, and obtaining Schedule II drugs by fraud. An OIG and Drug Enforcement Administration (DEA) investigation resulted in the defendant being charged with stealing oxycodone, hydrocodone, and promethazine/codeine syrup and diverting the narcotics into the community. Viagra and Cialis were also diverted. The investigation is ongoing and charges are pending against additional subjects.

Veteran Sentenced for Drug Distribution

A veteran was sentenced to 12 months’ incarceration and three years’ supervised release after pleading guilty to possession with intent to distribute a controlled substance. An OIG, VA Police Service, and local law enforcement investigation resulted in the defendant, who was previously enrolled in an inpatient substance abuse treatment program, being charged with selling crack cocaine at the Canandaigua, NY, VAMC. The defendant has been held in custody for violating his order of release.

Non-Veteran Sentenced for Drug Distribution

A non-veteran was sentenced to 5 years’ incarceration (2 years suspended) and three years’ probation after pleading guilty to drug distribution. The defendant was arrested after selling heroin during an undercover operation. An OIG, VA Police Service, and local police investigation was initiated after a veteran inpatient died from a heroin overdose at the West Haven, CT, VAMC. During the investigation, it was alleged that the defendant was supplying heroin to VAMC employees who in turn were distributing the drugs at the medical center.

Veteran Pleads Guilty to Travel Benefit Fraud

A veteran pled guilty to Grand Larceny. A VA OIG, New York State Medicaid OIG, and NY District Attorney's Office investigation resulted in the defendant being charged with receiving Medicaid-funded transportation to and from the Montrose, NY, VAMC on 747 occasions while also claiming and receiving VA travel benefits for the same travel. The loss to VA is \$19,079.

ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership if, during the course of an investigation, allegations are unsubstantiated or allegations are substantiated but no recommendations are made.

OIG's intention is to maintain transparency with veterans, Congress, and the public by releasing information related to administrative investigative work completed by OIG. As other administrative investigation advisories are completed, they may be available on our website.

You may view and download these administrative investigation advisories by clicking on the link to our webpage at <http://www.va.gov/oig/publications/aia-summaries.asp>.

Administrative Investigation Advisories (August 2016)	
Advisory Number	Title
15-05252-329	Alleged Misuse of Sick Leave, Board of Veterans Appeals, VA Central Office, Washington, DC



MICHAEL J. MISSAL
Inspector General