Department of Veterans Affairs
Office of Inspector General
April 2012 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspectors General Tell Senate Veterans' Affairs Committee That Veterans Are Not Receiving Timely Mental Health Evaluations and Treatment, Better Performance Metrics Needed

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, and John D. Daigh, Jr., M.D., AIG for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States Senate, on the results of a recent Office of Inspector General (OIG) report, *Veterans Health Administration – Review of Veterans' Access to Mental Health Care*. OIG found that VA's performance metrics are not a reliable measurement of Veterans' access to mental health (MH) care. The Veterans Health Administration (VHA) did not provide first-time patients with timely MH evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. As a result, performance measures used to report patient's access to MH care do not depict the true picture of a patient's waiting times to see a MH provider. While no measure will be complete, meaningful analysis and decision-making requires reliable data. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer, Director of the OIG's Kansas City Office of Audits and Evaluations. Dr. Daigh was accompanied by Michael Shepherd, M.D., Senior Physician in OIG's Office of Healthcare Inspections. [Click here to access testimony.]

ADMINISTRATIVE INVESTIGATIONS

Senior VHA Official Engaged in Improper Contracting Activities and Was Not Candid with Investigators, Health Administration Center, Denver, Colorado

An administrative investigation found that a VHA Senior Official engaged in improper contracting activities when she instructed her subordinates to issue sole-source task orders to one specific contractor and in a conflict of interest when she failed to maintain an arm's-length relationship with two VA contractors. She also violated VA policy when she sent VA contract proprietary information to her personal home computer and when she e-mailed a VA OIG draft audit report to one of the contractors about 1 month prior to her program office awarding them a task order that was consistent with the audit report. Further, she did not testify freely and honestly concerning her relationship to contractors and her involvement in the decision to award and administer the task orders. The investigation also disclosed that a VHA Senior Contracting Officer did not comply with Federal Acquisition Regulations pertaining to orders placed against Federal Supply Schedule contracts. [Click here to access report.]

OIG issued one restricted report this month, *Administrative Investigation, Failure to Properly Report a Felony to OIG, Interference with an OIG Investigation, and Lack of Candor, Lebanon VA Medical Center, PA* (Report No. 11-03720-153, Issued 04/11/12). The Freedom of Information Act office may be contacted with questions regarding this restricted report.

OIG REPORTS

Veterans Not Receiving Timely MH Evaluations and Treatment, Better Performance Metrics Needed

Congress and the VA Secretary requested the OIG determine how accurately VHA records wait times for MH services for both new patients and established patient's visits and if the wait time data VHA collects is an accurate depiction of the Veterans' ability to access those services. VHA policy requires all first-time patients referred to or requesting MH services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The review found VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to MH care services. VHA did not provide first-time patients with timely MH evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. As a result, performance measures used to report patient's access to MH care do not depict the true picture of a patient's waiting time to see a MH provider. The Under Secretary for Health concurred with the OIG's findings and recommendations. [Click here to access report.]

OIG Urges Greater Oversight, More Training To Correct Continuing Issues Cleaning Medical Equipment at St. Louis, Missouri, VAMC

OIG conducted a review to follow-up on our March 2011 report, *Reprocessing of Dental Instruments, John Cochran Division of the St. Louis VA Medical Center, St. Louis, Missouri*. The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented. In the past 18 months, facility managers have taken corrective actions and some conditions identified in the 2011 OIG report have been resolved. However, recommendations 1 and 2 from our 2011 report will remain open until all action plans outlined by the facility are effectively implemented. These recommendations include: (1) monitoring for compliance of all appropriate elements of reusable medical equipment reprocessing, standard operating procedures (SOPs), staff training, and staff competencies; and (2) monitoring by the VISN Supply, Processing, and Distribution (SPD) Management Board to ensure that SOPs are in place and staff training and competencies are current. Recommendation 3 related to administrative actions was addressed and resolved. OIG made a new recommendation that the VISN Director require comprehensive baseline environment of care inspections of all SPD areas, and that identified deficiencies are promptly corrected and monitored for ongoing compliance. The VISN and Facility Directors concurred with our recommendations. OIG will follow up on planned corrective actions until they are completed. [Click here to access report.]

Closer Oversight Needed in HUD-VA Supported Housing Program for Homeless Veterans in Bay Pines, Florida

OIG reviewed allegations that a Veteran living in Housing and Urban Development (HUD)–VA Supported Housing (VASH) committed suicide; that he was considered high risk for suicide; that he did not have contact with a VA case manager (CM) for months prior to his death; that the CM supervisor only visited the Port Charlotte clinic once since being assigned to the position; and that the supervisor told a CM to "audit himself and

get his charts straight" after learning of the suicide. OIG substantiated that the Veteran committed suicide, but not that he had been identified as high risk for suicide, or that the Veteran did not see or speak to a CM during 9 of 18 months in the program. OIG substantiated that a supervisor visited the Port Charlotte clinic only once, but not that this was inappropriate. OIG could neither substantiate nor refute that a CM was told by the supervisor to "audit himself and get his charts straight" after learning of the suicide. OIG found that network and system level oversight of the HUD–VASH program needed improvement and that 23 of 25 other Veterans in the program did not receive required case management services. We recommended that the System Director ensure HUD–VASH program case management services are provided as required and that Network and System Directors implement measures to strengthen management controls and oversight. [Click here to access report.]

Audit Shows No Systemic Problem in Assignment of Duty Stations in VA Personnel Actions

At the request of Senator Charles Grassley, Ranking Member, Committee on the Judiciary, United States Senate, OIG conducted a VA-wide audit to determine whether VA has a systemic problem assigning incorrect duty stations and locality pay to employees. The Chairman and Ranking Member of the Committee on Veterans Affairs, United States Senate, also requested notification of our audit results. OIG determined VA does not have a systemic problem assigning incorrect duty stations and locality pay to employees across all VA organizations. OIG nonetheless identified 6 of 99 statistically sampled cases where VA assigned incorrect duty stations due to inadequately trained human resources personnel and lack of notification to supervisors of employee duty assignments. Consequently, VA overpaid a total of about $106,000 in locality pay from the time the errors first occurred. If problems assigning incorrect duty stations are not fixed, we project a total of approximately $1.4 million in potential monetary benefits over the next 5 years. [Click here to access report.]

Los Angeles, California, Healthcare System Cited for Transparency, Compliance with VA Policy in Response to Medication Errors

OIG conducted an oversight inspection to review actions taken to address and respond to adverse drug events (ADEs) that led to blindness in the treated eye of five patients at the VA Greater Los Angeles, CA, Healthcare System (HCS). OIG determined that Veterans Integrated Service Network (VISN) and facility leadership complied with VHA policy in taking immediate actions in response to these ADEs. They appropriately notified the patients and contacted the Food and Drug Administration and VHA leaders while ascertaining the cause of the ADEs. The facility's action of disclosing to the patients that a medication error occurred is consistent with VA's commitment to transparency. In addition, the facility convened an administrative board of inquiry (ABI) to address other administrative and patient safety issues. OIG recommended that the Facility Director ensure that the recommendations from the local and external reviews are implemented and monitored, that the ABI is completed in a timely manner, and that corrective actions in response to the ABI are taken if indicated. Management agreed with the findings and recommendation and provided an acceptable action plan. [Click here to access report.]

Improvements Needed in Quality of Care, Medical Record Completeness, and Peer Reviews at Sheridan, Wyoming, VAMC

OIG conducted an evaluation to determine the validity of allegations regarding poor quality of care and administrative issues at the Sheridan, WY, VAMC. OIG did not substantiate that the patient's care for his lung condition resulted in a terminal illness and permanent confinement in a hospice unit or that the level of care caused the patient's clinical deterioration, subsequent non-VA hospitalization, and need for prolonged inpatient care and rehabilitation. OIG substantiated that medical record documentation did not consistently include current clinical assessment of the respiratory problem, lung examinations, or follow-up information regarding the patient's response to antibiotic therapy. OIG substantiated that the treatment for the patient's elbow bursa infection was inadequate and the physician's documentation did not meet VHA standards. OIG did not substantiate that facility managers responded unprofessionally to the patient's or brother's concerns. OIG found that the cessation of prednisone did not meet the accepted practice in the management of long term, daily corticosteroid therapy and the facility did not conduct Peer Review for the lung and elbow issues. OIG made three recommendations. The VISN and Facility Directors concurred with our recommendations and provided acceptable action plans. [Click here to access report.]

OIG Identifies Deficiencies in Hearing Aid Repair Processes at Atlanta, Georgia, VAMC

OIG conducted a review to determine the validity of allegations from a complainant regarding efficiency and timeliness of the hearing aid repair process at the Atlanta, GA, VAMC. The complainant alleged that: (1) Audiology Clinic staff mismanaged the process used to track and monitor hearing aid repairs, resulting in delayed repairs and the possible loss of hearing aids; (2) Audiology Clinic staff did not keep an accurate log reflecting the status of the complainant's hearing aid repairs resulting in delays; (3) Audiology Clinic staff and VAMC leaders were difficult to contact; and (4) VAMC leaders did not adequately respond to written complaints. OIG recommended that the VAMC Director ensure that: (1) staff monitor the status of outstanding repairs and assess the timeliness of vendor completed repairs, and (2) staff document reasons for lost and damaged hearing aids and develop risk mitigation strategies. The VISN and VAMC Directors concurred with our recommendations and provided an acceptable action plan. [Click here to access report.]

Improvements Needed to Ensure Timely Access to MH Residential Programs at VA Eastern Colorado HCS

OIG assessed the merit of allegations concerning the quality of MH care at the VA Eastern Colorado HCS, Denver, CO. OIG did not substantiate the allegation that the patient was not provided or offered other treatment options in conjunction with medications. HCS providers, as well as providers at the other VHA facilities where the patient received services, offered the patient a variety of therapies in both outpatient and inpatient settings. OIG did not substantiate the allegation that VHA providers improperly managed the patient's psychiatric medications. The patient's medications were appropriate in terms of his diagnoses of bipolar disorder and post-traumatic stress disorder (PTSD), and the medications were managed appropriately. However, OIG

found that the patient's admission to a MH residential rehabilitation treatment program was delayed for reasons that were not supported by VHA policy. OIG made one recommendation to ensure timely access to MH residential rehabilitation treatment programs. The VISN and Facility Directors agreed with the finding and recommendation and provided an acceptable action plan. [Click here to access report.]

Improvements Needed in Competency Assessments of VA Registered Nurses
OIG completed an evaluation of registered nurse (RN) competency processes in VHA facilities. The purposes of the evaluation were to determine whether facilities: (1) established policy/process requirements for initial and ongoing RN competency assessment and validation, (2) addressed key components in competency assessment and validation documentation, (3) completed RN competency assessment and validation in accordance with local policy, and (4) identified actions to be taken when an individual cannot demonstrate competency. OIG conducted this review at 29 facilities during Combined Assessment Program reviews performed from April 1–September 30, 2011, and identified three areas where RN competency processes needed improvement. OIG recommended that specific RN competency assessment and validation requirements be established to ensure consistency among facilities, that competency validation documentation include all elements required by Joint Commission standards and local policy, that all competency documentation be present in competency folders and be current and validated, and that appropriate actions be taken when competency expectations are not met. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Pharmaceutical Company Pleads Guilty to Off-Label Marketing
Merck, a major U.S. pharmaceutical company, pled guilty to distribution of a misbranded drug and also entered into a civil agreement with the Government. Under the terms of the plea agreements, the company will pay a $321 million criminal fine and a $628 million civil penalty. VA will receive $28,486,500 as a result of the civil settlement. The plea and settlements are the result of a multi-agency investigation involving the company's off-label marketing and promotion of the drug Vioxx and false statements about the drug's safety.

Physician Sentenced for Possession of Child Pornography and Health Care Fraud
A physician who owned a medical services company was sentenced to 72 months' incarceration after pleading guilty to possession of child pornography and health care fraud. A VA OIG, Office of Personnel Management (OPM) OIG, Federal Bureau of Investigation, Health and Human Services OIG, and Defense Criminal Investigative Service (DCIS) investigation revealed that the defendant defrauded VA and other Federally funded insurance programs by submitting false claims and fraudulent invoices for the remote monitoring of nerve conduction studies. The investigation revealed that the physician was paying untrained, non-medical personnel to monitor the procedures and impersonate him on internet chat logs to make it appear as though he was present. During the course of the investigation, agents executed search warrants and seized several computers. Forensic analysis of the defendant's computer revealed that he was spending most of his time viewing child pornography while he was allegedly monitoring

nerve conduction studies. The loss to VA is $64,759. A global settlement is currently being negotiated.

Service-Disabled Veteran-Owned Small Business Contractor Pleads Guilty to Wire Fraud

A Service-Disabled Veteran-Owned Small Business (SDVOSB) contractor was charged as a corporation and pled guilty to wire fraud. In addition, another Federal contractor was charged as a corporation and pled guilty to wire fraud and making false statements associated with the Federal Surplus Property Program. An OIG investigation, conducted with eight other agencies, revealed a fraudulent scheme to secure $21,513,300 in SDVOSB contracts, $1,657,231 in HUBZone (Historically Underutilized Business Zones) contracts, $613,995 in minority contracts, and $1,200,000 in fraudulently secured Federal surplus property. As a stipulation of the plea agreements, the registered owners of these corporations cooperated and provided information associated with the principal subject of this investigation.

Roseburg, Oregon, VAMC Pharmacy Technician Charged with Theft of Government Property

A Roseburg, OR, VAMC pharmacy technician was charged with theft of Government property. An OIG investigation revealed that for 18 months the defendant diverted over 6,000 tablets of Schedule II narcotics from the VA pharmacy. As part of the scheme, the defendant used her position and access to a VA computer to remove Schedule II narcotics from the pharmacy inventory and avoided audit detection by designating that the narcotics were being transferred to an automated drug dispenser located elsewhere in the medical center. The defendant also manipulated other security protocols in order to divert the drugs. It is estimated that the stolen drugs had a “street value” of $250,000. The actual loss to VA is approximately $26,000. In February 2012 OIG forwarded a Management Implication Notification to VHA informing them of weaknesses in VA’s control of narcotics located within controlled areas of the pharmacy.

Former United Parcel Service Employee Indicted for Theft of VA Drugs

A former United Parcel Service (UPS) employee was indicted for obtaining a controlled substance by fraud and theft of property. An OIG investigation determined that the defendant stole approximately 12 VA drug packages from a UPS hub warehouse between September 2010 and January 2011. The defendant admitted to stealing VA controlled substances from UPS packages on at least two occasions in January 2011 for personal use.

U.S. Postmaster Pleads Guilty to Theft of Mail Containing Controlled Substances

A U.S. Postmaster pled guilty to theft of mail after a VA OIG and U.S. Postal Service (USPS) OIG investigation revealed that he intercepted 14 packages containing controlled substances being shipped from the Murfreesboro, TN, Consolidated Mail Outpatient Pharmacy to Veterans in Louisiana. A search incident to arrest disclosed a satchel in the defendant’s locker containing additional VA narcotic bottles.

Huntington, West Virginia, VA Regional Office Employee Indicted for Forging U.S. Department and Agency Seals
A Huntington, WV, VA Regional Office employee was indicted for forging U.S. department and agency seals and applying them onto approximately 2,800 counterfeit military certificates. An OIG, Naval Criminal Investigative Service, and DCIS investigation revealed that from approximately July 2008 to October 2010 the defendant operated an Internet website and eBay store that sold the counterfeit military certificates bearing forged department and agency seals to the public. The investigation also revealed that the defendant was conducting some of the business related to this scheme from his assigned VA computer. The public fraud associated with this investigation has been determined to be approximately $50,000.

AmeriCorps Member Sentenced after Pleading Guilty to Burglary and Sexual Offense at Perry Point, Maryland, VAMC
An AmeriCorps member, formerly residing in leased housing at the Perry Point, MD, VAMC, was sentenced to 7 years' incarceration (4 years suspended), 3 years' supervised release, and ordered to register as a tier one sex offender after pleading guilty to burglary and a sex offense. An OIG and Maryland State Police investigation revealed that the defendant sexually assaulted a female AmeriCorps member at her residence located on the grounds of the medical center.

Veteran Pleads Guilty to Forcibly Touching a VA Nurse at Rochester, New York, Clinic
A Veteran pled guilty to forcibly touching a VA nurse. An OIG, VA Police Service, and local police investigation revealed that the defendant sexually assaulted a VA registered nurse during an appointment at the Rochester, NY, VA Community Based Outpatient Clinic (CBOC). When interviewed, the defendant admitted to placing the nurse's hand on his genitals while the nurse was performing a blood draw at the phlebotomy clinic.

Veteran Sentenced for Setting Fire to Jacksonville, North Carolina, Clinic
A Veteran was sentenced to 10 to 12 months' incarceration and ordered to pay $2,494 in court costs after pleading guilty to felonious burning of a public building. An OIG, VA Police Service, and local police investigation revealed that the defendant broke into the Jacksonville, NC, VA CBOC in the early morning and set fire to an office in the facility. There were no injuries; however, the entire clinic has smoke and water damage. The defendant claimed to have set the fire because of dissatisfaction with his VA services.

Former Reno, Nevada, Canteen Manager Pleads Guilty to Theft
A former canteen manager at the Reno, NV, VAMC pled guilty to theft of Government property. An OIG investigation revealed that during an 18-month period the defendant embezzled $42,111 by routinely removing money from 13 vending machines and then underreporting the vending machine sales. The canteen manager confessed to OIG agents that he used the embezzled money to support his gambling addiction.

Veteran Pleads Guilty to Assault of Reno, Nevada, VAMC Police Chief
A Veteran pled guilty to assaulting the Reno, NV, VAMC Police Chief. The defendant, while intoxicated, became disruptive in the medical center waiting area, made threats toward his primary care physician, and intimidated staff and patients. The chief arrived on scene, identified himself to the defendant and attempted to calm the situation. The defendant subsequently punched the chief in the face, causing injuries.

Atlanta, Georgia, VAMC Employee Indicted for Making Terroristic Threats
A VA employee was indicted for making terroristic threats. An OIG investigation revealed that the defendant told several staff members at a private medical center that he intended to kill his VA supervisors and the acting Assistant Director at the Atlanta, GA, VAMC if he did not receive a favorable decision regarding his pending Equal Employment Opportunity complaint. The defendant threatened to shoot and kill the supervisors during the medical center's weekly staff meeting and to kill the acting Assistant Director in his office. The defendant also stated that he would kill anyone else, including VA Police Officers, if they attempted to stop him.

Former Guardian Sentenced for Theft of Government Funds
A former VA approved guardian was sentenced to 27 months' incarceration and ordered to pay $305,126 in restitution ($197,678 to VA) after pleading guilty to theft of Government funds. A VA OIG, Social Security Administration (SSA) OIG, and local sheriff's investigation revealed that for 6 years the defendant embezzled funds from two Veterans. The defendant concealed her fraudulent activity by transferring funds between the two Veterans' accounts when filing required documentation.

Former VA Fiduciary Pleads Guilty to Misappropriation
A former VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation disclosed that the defendant, who was the VA appointed fiduciary for her brother-in-law, embezzled more than $70,000 of the Veteran's benefits. The defendant used the stolen money to build an addition to her home.

Wife of Fiduciary Pleads Guilty to Conspiracy and Filing a False Tax Return
A legal assistant, who was married to a VA fiduciary, pled guilty to conspiracy and filing a false tax return. The defendant and her husband, an attorney who served as a court appointed guardian and Federal fiduciary for 54 Veterans, stole approximately $2.3 million from the Veterans' bank accounts and then failed to report the stolen funds to the Internal Revenue Service (IRS). The husband is awaiting trial scheduled for August 2012.

Veteran Indicted for Possessing Child Pornography
A Veteran was indicted for possessing child pornography. An OIG and VA Police Service investigation determined that the defendant, who was residing in a VA transitional residence, viewed and printed images of child pornography in the computer room of the residence. The OIG Computer Crimes and Forensics Laboratory assisted in this investigation by conducting a forensic examination of the computers.

Son of Deceased VA Beneficiary Sentenced for Theft
The son of a deceased VA beneficiary was sentenced to 90 days' incarceration, 3 years' probation, and ordered to pay $103,866 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole $103,866 in VA funds that were issued after his father's death in February 2003.

Subjects Arrested for Identity Theft
Two non-veteran subjects were charged with identity theft, obtaining property or monies by false pretenses, and felony conspiracy after an OIG, local sheriff's office, and corporate security investigation revealed that the subjects used the identities of multiple victims, 13 of whom are Veterans, to fraudulently open over 150 Time Warner Cable accounts and sell them to several people in North Carolina. Seventeen additional non-veteran subjects were charged with obtaining property or monies by false pretenses for fraudulently purchasing and utilizing the victims' identities to maintain the cable accounts. To date, 11 of the 19 subjects have been located and arrested. Based on the number of military service members and Veterans who are victims, it is suspected that some of the victim's identities may have been stolen from a VA database. One of the two primary defendants, who was arrested, was also charged with being a conspirator in obtaining the victims' identities, but to date has been uncooperative in revealing the source of the stolen identification.

Veteran Pleads Guilty to False Writing
A Veteran pled guilty to false writing after an OIG and DCIS investigation revealed that he submitted a fraudulently produced DD-214 to VA and the Department of Defense (DoD). The fraudulent DD-214 reflected that the defendant had been awarded a Purple Heart and a Combat Infantry Badge and that he served 6 years in the U.S. Army. The fraudulent DD-214 allowed the defendant to qualify for VA compensation benefits for PTSD. The defendant also created another fraudulent DD-214 that was used as the basis to receive a military retirement. The loss to VA is approximately $28,400 and the DoD retirement overpayment is $93,029.

Veteran Admits to Defrauding VA
A Veteran signed a pre-trial diversion agreement in which he admitted to concealing his employment and providing false statements to VA in order to receive VA individual unemployability benefits. As part of the agreement, the defendant paid $10,000 in restitution to VA and will be on probation for 1 year. VA has also proposed reducing the Veteran's benefits that could result in an overpayment in excess of $172,000. An OIG investigation revealed that the Veteran was running a logging business while receiving the individual unemployability benefits.

Daughter of Deceased VA Beneficiary Arrested for Theft of VA Funds
The daughter of a deceased VA beneficiary was arrested at the Atlanta International Airport after returning to the U.S. from Dubai. The defendant was indicted in Arizona in July 2011 for theft of Government funds. An OIG investigation revealed that the defendant stole $104,000 of VA benefits by posing as her deceased mother after her death in December 2001.

Granddaughter of Deceased Beneficiary Arrested for Theft
The granddaughter of a deceased VA beneficiary was indicted and subsequently arrested for theft, wire fraud, and Social Security fraud. A VA OIG, OPM OIG, SSA OIG, HUD OIG, and U.S. Secret Service investigation revealed that the defendant fraudulently received, forged, and negotiated VA and OPM benefit checks issued after her grandmother's death in April 1986 until June 2007. In addition, the defendant failed to disclose her fraudulently obtained VA and OPM benefit income to the SSA and HUD from which she was also obtaining benefits. The total Government loss is approximately $222,641.

Veteran Arrested for Theft of Government Funds
A Veteran was indicted and subsequently arrested for theft of Government funds. A VA OIG, USPS OIG, and SSA OIG investigation revealed that the defendant, who was in receipt of VA individual unemployability benefits as well as other Federal disability benefits, reported to VA that he was unemployed and had no income. The investigation determined that the defendant was employed as a bishop of a church and was the owner and operator of a daycare center. The total Government loss is approximately $900,000, with a loss to VA of approximately $221,500.

Veteran Sentenced for Theft of Government Funds
A Veteran was sentenced to 48 months' incarceration, 3 years' supervised release, and ordered to pay $668,647 in restitution, to include $252,051 to VA. A VA OIG, IRS Criminal Investigation Division, SSA OIG, and Department of Education OIG investigation resulted in the defendant and his wife being convicted at trial of multiple charges of tax fraud, VA compensation fraud, Education, and Social Security fraud. The defendant fraudulently received VA individual unemployability benefits since 1986.

Veteran Sentenced for Theft of VA Travel Benefit Funds
A Veteran was sentenced to 4 months' probation and ordered to pay VA restitution of $36,175 after pleading guilty to theft of Government funds. An OIG and VA Police Service investigation revealed that on 313 occasions the defendant claimed he was traveling 330 miles roundtrip between Goddard, KS, and the Oklahoma City, OK, VAMC, when in actuality he resided within the Oklahoma City area.

Veteran Arrested with Assistance of OIG
The OIG assisted a U.S. Marshals Service Fugitive Apprehension Task Force with locating and apprehending a Veteran at the Little Rock, AR, VAMC. The Veteran was wanted for Failure to Appear for Felony Sexual Assault in the 2nd Degree.

VA Employee Arrested for Probation Violation
The OIG and VA Police Service arrested a Bonham, TX, VAMC employee for a probation violation stemming from an assault by strangulation charge.

(*original signed by Richard J. Griffin, Deputy Inspector General for:)*
GEORGE J. OPFER
Inspector General