Department of Veterans Affairs
Office of Inspector General
May 2012 Highlights

CONGRESSIONAL TESTIMONY

House Veterans' Affairs Committee Hears from Assistant Inspectors General on Findings That Veterans Are Not Receiving Timely Mental Health Evaluations and Treatment

Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, and John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States House of Representatives on the results of a recent Office of Inspector General (OIG) report, *Veterans Health Administration – Review of Veterans' Access to Mental Health Care*. The OIG found that the VA's performance metrics are not a reliable measurement of Veterans' access to mental health care. 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 the OIG's Office of Healthcare Inspections (OHI). [Click here to access testimony.]

Assistant Inspectors General Testify on VA's Prosthetics Clinical and Purchasing Practices Before the House Veterans' Affairs Subcommittee on Health

Ms. Halliday and Dr. Daigh testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives on three OIG reports dealing with prosthetics and the delivery of care, and contracting and supply issues, *Healthcare Inspection – Prosthetic Limb Care in VA Facilities*; *Veterans Health Administration – Audit of the Management and Acquisition of Prosthetic Limbs*; and *Veterans Health Administration – Audit of Prosthetics Supply Inventory Management*. On the clinical side, the OIG found that VA prosthetics staff were appropriately certified and that Veterans with amputations adjusted to life with their artificial limbs as well as those in the civilian population. The study also found that Veterans with amputations are significant users of VA health care services. The OIG found that VA needs to improve contract management and inventory management practices. Ms. Halliday was accompanied by Mr. Nick Dahl, Director of the OIG's Bedford Office of Audits and Evaluations, and Mr. Kent Wrathall, Director of the OIG's Atlanta Office of Audits and Evaluations. Dr. Daigh was accompanied by Robert Yang, M.D., Physician in the OIG's OHI. [Click here to access testimony.]

VA Prosthetics Contracting Practices Are Subject of House Veterans' Affairs Subcommittee on Oversight and Investigations Hearing

Ms. Halliday testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on contracting and inventory issues facing VA's Prosthetics program, focusing on two OIG reports, *Veterans Health Administration – Audit of the Management and Acquisition of Prosthetic Limbs*, and *Veterans Health Administration – Audit of Prosthetics Supply Inventory Management*. Our reports found that better management and oversight of

contracts could save VA over $35 milion and avoid disruptions to patients. Ms. Halliday was accompanied by Mr. Dahl and Mr. Wrathall. [Click here to access testimony.]

OIG REPORTS

VA's Fast Pay System for Drugs Purchased from Prime Vendor Is Effective, But Quicker Fix of Pricing Differences Needed

At the request of the VA Secretary and the House Committee on Veterans' Affairs, the OIG reviewed VA's Fast Pay system. This system processed $4.3 billion of pharmaceutical prime vendor purchases in fiscal year (FY) 2011. OIG found Fast Pay consistently provided payments within 48 hours and VA paid accurate contract prices for purchased supplies. However, the National Acquisition Center had not resolved pricing differences of about $46.4 million for pharmaceutical prime vendor purchases from December 2009 through April 2011. In addition, inadequate segregation of ordering and receiving duties makes VA vulnerable to fraudulent activity. OIG recommended VA timely resolve and recover purchase pricing errors and timely completion of price analyses, as well as proper segregation of supply ordering and receiving duties, and adequate verification of supply receipts. The Department concurred with our findings. [Click here to access report.]

Marion, Illinois, VAMC, Faulted for Privileging, Peer Review, and Lack of Qualified Staff Available 24/7 for Airway Emergencies

OHI received four complaints between October 2011 and January 2012 regarding the clinical practice of two physicians of the Marion, IL, VA Medical Center (VAMC). In February 2012, Senator Richard J. Durbin forwarded additional allegations concerning one of the physicians. In the care of one patient, the risk of complications requiring urgent intervention should have been discussed with the patient as part of the informed consent process prior to a procedure, at which time the patient's therapeutic preferences could have been clarified. OIG identified no deficiencies in quality of care for two other patients. OIG also found that a physician who was hired after not being in clinical practice for many years was granted clinical privileges with the understanding that his competence would be confirmed by direct observation. However, competence was never documented for invasive procedures that he subsequently performed. OIG recommended that the Facility Director ensure that Veterans Health Administration (VHA) and local policies are followed when initial clinical privileges are granted, peer review processes comply with VHA policy, staff with demonstrated competence in airway management are available 24 hours a day, 7 days a week, an Intensive Care Unit (ICU) Director is appointed, and the facility adheres to local policy regarding the use of ICU beds. The Acting Veterans Integrated Service Network (VISN) Director and Facility Director agreed with our findings and recommendations and provided acceptable action plans. [Click here to access report.]

IG Publishes First-Ever Longitudinal Study on Incidence and Risk Factors of Becoming Homeless After Military Service

Preventing Veterans from becoming homeless is an integral strategy of eliminating homelessness in Veterans. Using integrated data from VA and the Department of Defense (DoD), OIG conducted this first ever population-based longitudinal study to

determine the incidence of becoming homeless (the newly homeless) after military separation, identify risk factors for Veterans becoming homeless, and describe utilization of VA specific homeless services by homeless Veterans. The study population consists of 310,685 Veterans who separated from the military from July 1, 2005, to September 30, 2006, and who had not experienced any homeless episodes before separation from DoD. OIG found that 3.7 percent of these Veterans had experienced their first episode of homelessness at 5 years after separation. Veterans of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) and women Veterans experienced higher incidences of homelessness. Veterans who experienced homelessness were younger, enlisted with lower pay grades, and were more likely to be diagnosed with mental disorders and/or traumatic brain injury (TBI) at the time of separation from active duty. OIG found that the presence of mental disorders (substance-related disorders and/or mental illness) is the strongest predictor of becoming homeless. Military sexual trauma is also a risk factor for becoming homeless, especially in women Veterans. OIG noted that the percent of mental disorder diagnoses among newly homeless OEF/OIF Veterans was higher than those of their non-OEF/OIF counterparts prior to becoming homeless, although the percent of OEF/OIF Veterans diagnosed with mental disorders before discharge from DoD was generally lower than their non-OEF/OIF counterparts. The Under Secretary for Health concurred with our findings and recommendation and provided acceptable action plans. [Click here to access report.]

Opportunities Exist for VBA To Improve Processing of Rating Decision Appeals at VA Regional Offices

OIG determined whether opportunities exist to improve VA Regional Office (VARO) timeliness in processing appeals of rating decisions. The nationwide inventory of appeals increased over 30 percent to about 209,000 in FY 2010 and the inventory of compensation rating claims also increased by 40 percent to 532,000 claims. Opportunities exist to improve appeals processing at regional offices. Regional office managers did not assign enough staff to process appeals, diverted staff from appeals processing, and did not ensure appeals staff acted on appeals promptly because compensation claims processing was their highest priority. OIG found the *de novo* review process results in quicker decisions on Veterans' appeals because decision review officers can render new decisions without awaiting new evidence as required with traditional reviews. VARO staff did not properly record 145 appeals in the Veterans Appeal Control and Locator System that delayed processing for an average of 444 days. The Under Secretary for Benefits generally agreed opportunities exist to improve appeals processing and stated the Veterans Benefit Administration (VBA) was conducting a pilot program to assess the feasibility of implementing most of our recommendations. OIG will follow up on the implementation of the corrective actions. [Click here to access report.]

IG Makes Five Recommendations To Improve Management of Enteral Nutrition Safety Across VA Medical System

OIG completed an evaluation of the management of enteral nutrition (EN) safety in VHA facilities. The purposes of the evaluation were to determine whether facilities complied

with Joint Commission standards and VHA requirements to: (1) establish and implement EN policies and practices, (2) manage and document EN care in the electronic health record (EHR), and (3) provide continuity of care for patients receiving EN. OIG also determined whether facilities incorporated selected safe EN practices as recommended by the American Society for Parenteral and Enteral Nutrition. OIG conducted this review at 27 facilities during Combined Assessment Program (CAP) reviews performed from April 1 to September 30, 2011, and identified five areas with opportunities for improvement. OIG recommended that current VHA requirements be evaluated and revised to include applicable industry recommendations regarding EN safety practices and documentation. OIG also recommended that facility policies and practices address all VHA-required EN elements; that EHR documentation consistently include all VHA-required EN elements; that clinicians provide EN education for patients discharged on EN and/or their caregivers; and that facilities strengthen continuity of care processes for follow-up and monitoring of patients discharged on EN. [Click here to access report.]

VA's Measures to Protect Sensitive Data on Mobile Devices Meet Federal Security Standards, But Better Inventory Needed

In response to a confidential hotline allegation, OIG evaluated whether VA's approach for information system certification and storing sensitive data on Apple mobile devices circumvents information security requirements. Senator Kyl also requested OIG evaluate whether VA's approach for only storing sensitive data on encrypted mobile device applications meets Federal Information Security Management Act (FISMA) requirements. OIG determined VA was not circumventing FISMA certification and accreditation requirements by suspending security control testing and granting operational waivers for existing information systems. OIG also determined that VA's approach for allowing only certified applications to access sensitive data or storing encrypted data on the mobile device met FISMA information security requirements for data protection. However, OIG noted that VA could improve management controls by ensuring an accurate inventory and consistent configuration of mobile devices deployed enterprise-wide. The Assistant Secretary for Information and Technology concurred with our findings and recommendations. [Click here to access report.]

IG Issues Annual Summary on VHA's Quality Management Programs, Recommends Six Areas for Improvement

OIG completed an evaluation of the management of VHA medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. OIG conducted this review at 54 facilities during CAP reviews performed from October 1, 2010, through September 30, 2011, and identified six areas with opportunities for improvement. OIG recommended that VHA reinforce requirements for facility senior managers to actively participate in the review of well-integrated QM/performance improvement results; Peer Review Committees to submit quarterly reports to their Medical Executive Committees; completed corrective actions related to peer review to be reported to the Peer Review Committee; EHR committees to provide

oversight and analyze EHR quality and unauthenticated documentation at least quarterly and to include all services in EHR quality reviews; routine monitoring of EHR entries for inappropriate copy and paste use and quarterly reporting to the EHR committee; and all facilities with acute inpatient beds to have documented plans addressing patients who must be held in temporary beds and overflow locations. [Click here to access report.]

Unauthorized Practice of Medicine at a VA Medical Center Unsubstantiated
OIG conducted an oversight inspection to determine the validity of allegations of the unauthorized practice of medicine. A complainant alleged that a non-physician staff (subject staff) at a VAMC Emergency Department (ED) engaged in the unauthorized practice of medicine by representing himself as a doctor, and that the ED nurse manager was aware of this behavior but did not take action to correct it. The complainant also alleged that the subject staff intubated a patient during an emergency resuscitation causing the patient's death and that, in another instance, the subject staff pronounced a patient dead. The facility conducted an internal investigation and took corrective actions. The investigation found that the subject staff acted outside the scope of his duties by responding to and participating in a "code blue" event. The facility did not find that the subject staff engaged in the unauthorized practice of medicine. OIG reviewed all documents produced during the facility's investigation, pertinent medical records, and other administrative records, and interviewed facility staff. OIG concurred with the findings of the facility and found the corrective actions to be appropriate. OIG made no recommendations. [Click here to access report.]

Northport, New York, VAMC Needs To Strengthen Pain Management and Clinical Disclosure Policies
OIG reviewed five allegations regarding a patient's fall at the Northport VAMC. Due to insufficient documentation, we were unable to confirm or refute the allegation that the staff member assigned to monitor the patient was not present when the patient fell. OIG also did not substantiate the allegations that the facility did not perform adequate tests after the patient's fall and that a surgical stapling procedure was performed at the patient's bedside. OIG substantiated that the patient did not receive effective and timely pain management and that the facility did not appropriately disclose clinical information and respond to the family's complaints. OIG recommended that the Medical Center Director strengthen processes to ensure that documentation for one-to-one monitoring of patients is accurate, the facility reassess the incident reporting process for effectiveness, the facility implement procedures to ensure that facility staff comply with VHA pain management policies and VHA and local clinical disclosure policies, and that facility responses to patient and family complaints are timely and facilitate resolution. The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. [Click here to access report.]

Allegations of Telemetry Equipment Deficiencies Unsubstantiated, But Improvements Needed in Patient Response Timeliness
OIG conducted an inspection to assess the merit of an allegation made by a complainant concerning quality of care of a patient on a telemetry unit at the Manhattan

Campus, New York Harbor Healthcare System. OIG did not substantiate that a telemetry equipment malfunction contributed to the patient's death. OIG found that the telemetry equipment was functioning properly and that biomedical engineering personnel conducted preventive maintenance in accordance with the manufacturer's specifications. OIG substantiated that staff on the telemetry unit failed to respond to a patient's disconnected telemetry lead in a timely manner; as a result, the patient's telemetry status was not effectively monitored at the time of his death. During the inspection OIG reviewed progress on corrective actions taken to address deficiencies related to a prior incident addressed by the OIG in an October 2011 report. Regarding both incidents, facility management had developed and initiated a comprehensive corrective action plan to address all deficiencies identified by internal review and the previous OIG inspection. OIG concluded that managers have made significant progress in all elements of the corrective action plan. OIG made no recommendations. [Click here to access report.]

Improvements Needed in Patient Assessment at the William Jennings Bryan Dorn Columbia, South Carolina, VAMC

OIG evaluated allegations of inadequate patient care, poor communications with family, poor coordination of care, and inappropriate infection control practices. While OIG confirmed that some of the alleged conditions existed during a Veteran's hospitalization, in many cases, facility leaders had already taken actions to improve care and service delivery. OIG did not substantiate other allegations related to quality of care and environmental deficiencies. OIG recommended that patients assessed to be at nutritional risk are promptly evaluated by appropriate dietary staff, that nursing personnel are trained on the steps required to initiate consult requests through the electronic nursing assessment package, and that actions are taken to evaluate and revise the Do Not Attempt Resuscitation template note, as appropriate, to be more patient-specific and patient-centered. The VISN and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. [Click here to access report.]

Deficiencies Regarding the Surgery Program Are Reviewed at the Grand Junction, Colorado, VAMC

OIG's conducted an oversight review to assess actions taken by VISN 19 and Grand Junction VAMC leadership regarding the VAMC's surgical program. Between May and September 2011, VHA surgery and QM teams made onsite visits to the Grand Junction VAMC. They identified concerns related to the surgery program and other issues. After the October CAP review and Employee Assessment Review survey, the OIG received allegations from facility staff. The allegations related to an increase in surgical infections and perforations, documentation, ED triage and surgical referral, resources, QM program, scheduling, reusable medical equipment and safety. Because the VHA teams had previously reviewed most of the allegations, OIG conducted an oversight review to determine if the facility and VISN adequately addressed the concerns and allegations. OIG found that action plans had been developed to address these allegations and concerns. OIG recommended that the VISN Director continue to

monitor facility action plans to ensure effective and complete follow up. [Click here to access report.]

Benefits Inspection Division Visits Los Angeles, Oakland, and San Diego, California

OIG Benefits Inspection Division conducted an inspection at the Los Angeles VARO to evaluate how well it accomplishes its mission. OIG found the Los Angeles VARO staff provided adequate outreach to homeless shelters and followed the policy for correcting errors identified by Systematic Technical Accuracy Review (STAR) staff. However, it lacked effective controls and accuracy in processing some disability claims. VARO staff did not accurately process 54 (60 percent) of 90 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO. Staff used insufficient medical examination reports to process TBI claims. Further, errors in herbicide exposure-related disability claims occurred because staff incorrectly interpreted policy. VARO management did not ensure staff properly processed mail, or accurately addressed Gulf War Veterans' entitlement to mental health treatment. Further, inadequate monitoring of corrective actions on prematurely closed claims and lack of management controls over the processing of oldest pending claims resulted in significant delays. The VARO Director concurred with our findings and recommendations. The planned corrective actions are responsive and we will follow up as required on all actions. [Click here to access report.]

OIG conducted a similar review at the Oakland VARO. OIG found the Oakland VARO staff followed the policy for correcting errors identified through the STAR program and provided outreach to homeless shelters and service providers. VARO performance was generally effective in processing herbicide exposure-related disability claims. However, it lacked effective controls and accuracy in processing some disability claims. VARO staff did not accurately process 35 (39 percent) of 90 disability claims we sampled. These results do not represent the overall accuracy of disability claims processing at this VARO. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule or establish controls for future medical reexaminations. Staff incorrectly interpreted policy and used inadequate medical examinations to process TBI claims. VARO management did not ensure staff timely completed all elements of Systematic Analyses of Operations (SAOs), properly processed mail, accurately addressed Gulf War Veterans' entitlement to mental health treatment, or properly reviewed claims pending for more than a year. The VARO Director concurred with our findings and recommendations. The planned corrective actions are responsive and we will follow up as required on all actions. [Click here to access report.]

Lastly, OIG conducted an evaluation to determine how well the San Diego VARO accomplishes its mission. OIG found the San Diego VARO staff provided adequate outreach to homeless shelters and service providers. However, it lacked accuracy in processing some disability claims. VARO staff did not accurately process 42 (53 percent) of 79 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this

VARO. VARO staff did not always correct errors identified by the VBA's STAR program. Further, they did not always include all mandatory analyses or complete all elements of SAOs. VARO staff did not properly process mail or accurately address Gulf War Veterans' entitlement to mental health treatment. Delays occurred in processing claims pending more than 365 days when staff did not request adequate supporting evidence or timely follow up on past due actions. The VARO Director concurred with our findings and recommendations. The planned corrective actions are responsive and we will follow up as required on all actions. [Click here to access report.]

Inspection Results for VA Clinics in Multiple VISNs

OIG reviewed three Community Based Outpatient Clinics (CBOCs) during the week of January 9, 2012. CBOCs were reviewed in VISN 6 at Virginia Beach (Norfolk-Virginia Beach), VA; and, in VISN 10, at Bellevue, KY, and Hamilton, OH. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: short-term fee basis care, women's health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, and environment and emergency management. OIG noted opportunities for improvement and made a total of eight recommendations to the VISN and Facility managers. [Click here to access report.]

OIG reviewed four CBOCs during the weeks of January 30 and February 13, 2012. CBOCs were reviewed in VISN 8 at Fort Pierce and Sebring, FL; and in VISN 9 at Dyersburg, TN, and Smithville, MS. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: short-term fee basis care, women's health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, environment and emergency management, and CBOC contracts. OIG noted opportunities for improvement and made a total of 28 recommendations to the VISN and Facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Two Contractors Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

Two VA contractors were sentenced after pleading guilty to making illegal payments to a VA employee and defrauding the VA Service-Disabled Veteran-Owned Small Business Fraud (SDVOSB) program. An OIG investigation determined that the defendants set up a front company purportedly owned and operated by a service-disabled Veteran, when in fact it was controlled and managed by the contractors. The first defendant, who was the leader of the scheme, was sentenced to 2 years' incarceration, 1 year of probation, and a $50,000 fine. The other defendant was sentenced to 3 years' probation, a $60,000 fine, and ordered to pay VA $1,550,000 in restitution. A former VA employee previously pled guilty to a criminal information that charged him with accepting illegal gratuities from the contractors while he was the Director of Projects at the St. Louis, MO, VAMC. The VA employee admitted to

accepting approximately $20,000 in money, luxury baseball tickets, meals, and entertainment at a local club from the two contractors while he steered $3.4 million in SDVOSB set-aside contracts to the shell company.

Puerto Rico Man Charged with Fraud, Used Fake Social Security Card To Obtain Over $650,000 in VA Benefits
A Veteran was arrested for aggravated misappropriation, misrepresentation, fraud, and possession and transfer of false documents. This investigation resulted in the securing of legal standing from the Commonwealth of Puerto Rico's Attorney General enabling the OIG to become the first Federal law enforcement agency to have the ability to present criminal cases directly to the Commonwealth Attorney for prosecution. The investigation was initiated based on a referral from the St. Petersburg OIG Benefit Inspections Division, who identified the suspected fraud during an audit of the San Juan, PR, VARO. The investigation revealed that the defendant fraudulently received both VA compensation and pension benefits based upon multiple fraudulent enlistments in the U.S. Army and a fraudulent Social Security card. The loss to VA is $652,508.

Veteran Sentenced for Threats to VA Employees
A Veteran was sentenced to 15 months' incarceration, 1 year of supervised release, to include mandatory "no victim" contact during the entire time, after having previously been convicted of threatening two VA employees. An OIG investigation revealed that the defendant made a series of threatening phone calls to two VA employees at their residences.

Former Columbia, South Carolina, VAMC Employee Sentenced for Assault of VA Patient
A former Columbia, SC, VAMC employee was sentenced to 36 months' probation with the first 6 months consisting of home confinement. The defendant pled guilty to assault after he admitted fondling an amputee patient at the medical center, while reportedly checking the patient's diaper for wetness. The defendant's employment was terminated approximately 6 months following his indictment.

Former Cleveland, Ohio, VAMC Purchasing Agent Charged with Conspiracy
A former Cleveland, OH, VAMC purchasing agent working in the prosthetics department and the owner of a durable medical equipment provider were each charged by a criminal information with conspiracy to commit health care fraud. The former VA employee used her position to provide competitor's bid information to the medical equipment provider and allowed for inflated payments for services provided. Also, in some instances the equipment was not installed by the provider, either because the Veteran refused delivery or because the Veteran died prior to delivery. The provider then charged VA as if the equipment had been installed. The loss to VA is $110,581.

Tampa, Florida, VAMC Employee Arrested for Theft of Government Property
A Tampa, FL, VAMC employee was arrested for theft of Government property. An OIG investigation revealed that the defendant, who worked in the eye clinic, ordered

$78,240 in vision-enhancing equipment under the names of at least 34 Veterans. The defendant then sold the equipment on e-Bay for approximately $17,350.

VA Employee Charged with Theft of Government Property
The Information Security Officer at the Southern Oregon Rehabilitation Center (SORC) in White City, OR was charged with theft of Government property. An OIG and VA Police Service investigation revealed that the defendant stole VA computers that were stored at the facility and were later reported missing. A report of survey conducted by the SORC failed to account for at least four computers and they were subsequently removed from the property book. Three years later, information was received by VA Police describing how the defendant had stolen the computers. Local county detectives working on an unrelated case had discovered two computers at the employee's home during a search warrant. The serial numbers on the seized computers matched those missing from a VA report of survey.

Jackson, Mississippi, VAMC Associate Director Arrested for Fraudulently Obtaining Controlled Substances
An Associate Director at the Jackson, MS, VAMC was arrested for fraudulently obtaining controlled substances. An OIG and Drug Enforcement Administration investigation revealed that the VA employee was receiving overlapping prescriptions for the same controlled substance from VA and non-VA prescribers.

San Diego, California, VAMC Employee Charged with Illegally Obtaining Narcotics
A San Diego, CA, VAMC employee, who is also a Veteran, was charged with illegally obtaining narcotics from the VA pharmacy and burglary. An OIG and drug task force investigation determined that for over 3 years the defendant forged a VA physician's signature on prescriptions in order to obtain oxycodone. In addition to obtaining narcotics, the defendant also received non-controlled medications which he mailed to his residence. In addition to the drugs seized at the residence, agents also found VA medical records belonging to another Veteran.

United States Postal Service Contract Employee Arrested for Theft of VA Drugs
A United States Postal Service (USPS) contract truck driver was indicted and subsequently arrested for theft of mail. A VA OIG and USPS investigation revealed that during a 6 month period the defendant stole approximately 9,600 pills of VA controlled medication and more than 3,000 prescription pills from a non-VA hospital located in Asheville, NC. The defendant admitted to stealing the drugs for his own use and to sell.

Former Union President Indicted for Theft of Union Funds
A former New York, NY, VAMC employee and union president of an American Federation of Government Employee's local was indicted for theft of union funds while on U.S. Government property. An OIG and Department of Labor, Office of Labor Management Standards, investigation revealed that the defendant embezzled approximately $112,500 by writing 187 checks to himself from the union's checking account.

Fiduciary Sentenced for Embezzlement
The daughter of a Veteran, who was also his fiduciary, was sentenced to 18 months' incarceration, 2 years' supervised release, and ordered to pay $244,673 in restitution for her role in the embezzlement of VA compensation and Social Security benefits intended for her father. The defendant was previously charged in a criminal information with misappropriation by a fiduciary and conversion of Social Security benefits. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant became the Veteran's fiduciary in 2005 and for over 3 years embezzled from her father's savings. After initially claiming that a VA field examiner told her she could spend the money, she admitted to OIG agents that she fraudulently spent the money intended for the Veteran.

Veteran's Daughter Sentenced for Fiduciary Fraud
The daughter of a Veteran, who was also his fiduciary, was sentenced to 90 days' home confinement, 2 years' probation, and ordered to pay $16,020 in restitution after pleading guilty to representative payee fraud by a fiduciary. A VA OIG and SSA OIG investigation determined that the defendant stole Government funds intended for her father and used the funds for gambling and personal expenses.

Veteran Sentenced for Attempting to Defraud VA
A Veteran was sentenced to 5 years' probation after pleading guilty to possession of a false document with intent to defraud the United States. An OIG investigation revealed that the defendant attempted to defraud a VA Educational Assistance Program. During the course of the investigation, the Veteran presented an altered DD-214 to an OIG agent posing as a VA benefits officer.

Remarried Husband of Deceased Veteran Sentenced for Theft of VA Benefits
The remarried husband of a deceased Veteran was sentenced to 366 days' incarceration, 24 months' supervised release, a $10,000 fine, ordered to pay VA restitution of $185,458 (already paid), and to refrain from handling monetary or business affairs for any business or organization. The defendant had previously pled guilty to conversion of Government funds. An OIG investigation revealed that on three separate occasions the defendant falsely certified to VA that he had not remarried in order to continue to receive Dependency and Indemnity Compensation benefits.

Veteran's Girlfriend Sentenced for Fraud
The girlfriend of a Veteran was sentenced to 5 years' probation and ordered to pay VA $167,317 in restitution after conspiring to structure a business in her name in order to conceal the Veteran's income from VA. An OIG investigation revealed that the Veteran and his girlfriend operated a business for over 8 years while the Veteran received VA pension benefits and co-pay exempt VA health care. The investigation further revealed that the Veteran was also selling his VA-prescribed morphine tablets. Drug charges are pending against the Veteran.

Son of Deceased VA Beneficiary Sentenced for Theft of VA Funds
The son of a deceased Dependency and Indemnity Compensation recipient, who previously pled guilty to theft of public money, was sentenced to 36 months' probation, 6 months' electronic monitoring, and ordered to pay VA restitution of $64,539. An OIG investigation determined that the defendant stole VA funds that were direct deposited after his mother's death in March 2005.

Fugitive Veteran Arrested at Orange City, Florida, VA Outpatient Clinic
A Veteran was arrested without incident at the Orange City, FL, VA Outpatient Clinic by local police with the assistance of OIG. The defendant was wanted by the Albany, OR, Police Department on a felony warrant for luring a minor, furnishing sexually explicit material to a child, private indecency, online sexual corruption of a child, and sexual abuse.

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