



Department of Veterans Affairs

Office of Inspector General

August 2012 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General for Investigations Testifies on VA's Veteran-Owned and Service-Disabled Veteran-Owned Small Business Programs

James J. O'Neill, Assistant Inspector General for Investigations, testified before the Subcommittee on Oversight and Investigations and the Subcommittee on Economic Opportunities, Committee on Veterans' Affairs, United States House of Representatives, on the Office of Inspector General's (OIG) investigative work related to VA's Veteran-Owned and Service-Disabled Veteran-Owned Small Business (VOSB and SDVOSB) programs. Mr. O'Neill discussed the current caseload of OIG investigations involving the SDVOSB program, suspension and debarment actions that will exclude wrongdoers from receiving future contract awards, and significant prosecutions resulting from OIG investigations, including one where the defendant forfeited \$1.5 million and a 2011 Jaguar Series XKR Model XK, was sentenced to serve 3 years' probation, and ordered to pay \$1,550,000 in restitution and a \$60,000 fine. He concluded that by bringing criminals to justice, economic opportunities for legitimate service-disabled Veterans should increase. [\[Click here to access testimony.\]](#)

OIG REPORTS

Better Oversight of Costs and Broader Impact Measures Can Improve VA's Corporate Workforce Development Program

The Chairman of the Senate Committee on Veterans' Affairs requested OIG to assess how effectively VA manages its ADVANCE human capital program. OIG found VA achieved many of its human capital program goals with ADVANCE and its Corporate Senior Executive Management Office. Since fiscal year (FY) 2010, VA met its annual goal by training over 135,000 employees. However, VA needs to strengthen management of its Office of Personnel Management (OPM) interagency agreements and better assess program impact. With the rapid deployment of ADVANCE, VA did not establish adequate controls over interagency agreement costs and terms. OIG estimated, although data was limited, the standardized service fee applied during FY 2011 cost VA an additional \$2.5 million. OIG recommended VA assess whether its relationship with OPM is in VA's best interest and improve the ADVANCE program by developing processes to collect and monitor contractor costs as well as timely and complete information on interagency agreement terms and improve program impact measures. The Assistant Secretary concurred with the recommendations and provided plans to implement the recommendations. [\[Click here to access report.\]](#)

IG Finds Professional Staff Frustrated by Ineffectiveness of Senior Leadership at Iowa City HCS

OIG conducted a comprehensive review of the Iowa City VA Health Care System (HCS) in response to a request from Senator Charles E. Grassley. OIG assessed the merit of allegations about quality of care and that concerns expressed by staff "have been largely ignored." OIG found that high quality medical care has been maintained.

However, a pervasive lack of support for staff problem-solving is a potential threat to patient safety, and that several process deficiencies were identified. During a prolonged period when key leadership positions were held by individuals on a temporary basis, decisions were delayed or never made and a highly competent professional staff was frustrated by the persistent ineffectiveness of senior leadership. OIG recommended that the Veterans Integrated Service Network (VISN) Director ensure that system leaders take appropriate action in response to identified problems and communicate action plans to staff. OIG also recommended that system leaders clarify organizational lines of authority and responsibility and improve components of Environment of Care and Pharmacy management. [\[Click here to access report.\]](#)

Audit Estimates Veterans Health Administration Could Increase Third-Party Revenue by at Least \$152M Annually

OIG conducted this audit to determine the extent Veterans Health Administration's (VHA) Medical Care Collections Fund program identified third-party billing opportunities for VA-provided medical care. Our previous audit on Non-VA-provided medical care determined VA missed opportunities to increase third-party revenue by \$110.4M annually or \$552M over 5 years. VHA advised it improved its collections by 43 percent, from \$1.3B in FY 2007 to \$1.8B in FY 2011. However, our review of VA-provided care identified further opportunities to improve. Specifically, VHA lacked an effective review policy on unbilled care, did not adequately monitor insurance identification procedures, and needed increased training for staff. OIG estimated VHA missed opportunities to increase third-party revenue by at least \$152M annually. Without actions to improve billing processes, VHA could miss an estimated \$760M over the next 5 years. The Under Secretary for Health (USH) agreed with our finding, recommendations, and monetary benefits. [\[Click here to access report.\]](#)

Staff and Nuclear Medicine Machine Underutilized at VA Clinic in Marion County, Florida

A hotline complainant alleged the North Florida/South Georgia Veterans Health System of the VA Sunshine Healthcare Network underutilized The Villages Outpatient Clinic in Florida. OIG assessed the allegation that four operating rooms intended for minor surgeries and three procedure rooms had not been used since the clinic opened in October 2010. OIG substantiated the allegation that The Villages Outpatient Clinic was underutilized during the first 18 months of operation. OIG found primary care, mental health (MH), and specialty care were not being provided as planned. The surgical suite had not been used since the facility opened and the nuclear medicine suite was underutilized. As a result, VHA spent \$1.9 million on this underutilized facility and equipment costs as well as on staff salaries and benefits. These funds represent a lost opportunity to provide Veterans with additional access to medical care in an underserved area of need. OIG recommended VHA conduct a utilization review to ensure facility resources efficiently meet the medical needs of the most underserved Veterans. VHA agreed with our finding and recommendations.

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

VA Cancels Five Set-Aside Contracts for Claims Re-Pricing After IG Finds Improper Subcontracting to Large Business

OIG determined that Enterprise Technology Solutions, LLC (ETS) was not in compliance with the contract provisions limiting subcontracting. OIG found that ETS, a SDVOSB concern owned by a former VA employee, subcontracted the re-pricing requirements to Health Net, a large business for all five of its contracts. All five contracts were awarded as SDVOSB set-asides. The USH and the Chief Procurement and Logistics Officer agreed with our recommendation to terminate ETS's five contracts and to conduct an assessment to determine the value, if any, of re-pricing claims from non-VA providers. VA also concurred with our recommendation that VA ensure requirements are written to ensure former VA employees are not given an unfair advantage and that competition is achieved to the maximum extent practicable.

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

Probe Uncovers Lax Prescribing of Opiates at Calais VA Clinic

OIG conducted a review to determine the validity of allegations regarding management of chronic opioid therapy and opioid prescribing practices at the VA Maine HCS Community Based Outpatient Clinic (CBOC) in Calais, Maine. OIG substantiated the allegations that providers did not adequately assess patients who were prescribed opioid for chronic pain and did not adequately monitor patients for misuse or diversion of the opioid medications. OIG substantiated that managers asked providers to prescribe opioids for patients whom they had not assessed. OIG found that a chronic shortage in provider staffing at the clinic impacted the management of chronic opioid therapy. OIG made one recommendation to address these issues. Management agreed with the findings and recommendations and provided an acceptable improvement plan. [\[Click to access here.\]](#)

IG Visit Prompts VBA To Take Immediate Action To Fix Inadequate Claims Folder Storage at Winston-Salem Regional Office

During the onsite benefit inspection of the Winston-Salem VA Regional Office (VARO), OIG observed an excessive number of claims folders stored on the top of, and around, filing cabinets. Based on our concerns, OIG issued a Management Advisory Memorandum to the Under Secretary for Benefits to ensure the VARO addressed management of Veterans' files and employee safety concerns immediately. The inadequate storage created an unsafe workspace for VARO employees and appeared to have the potential to compromise the integrity of the building. The Under Secretary for Benefits directed VARO leadership to take immediate action to find alternate temporary storage areas, obtain additional storage cabinets, and relocate excess cabinets and exposed folders to other floors. VARO management complied and submitted a long-range proposal to improve claim folder access and security.

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

Lebanon VA Management React Quickly to Staff's Inadvertent Overexposure to Ultraviolet Light During Surgical Procedure

OIG conducted an inspection to determine the validity of allegations that a surgical patient and 10 Lebanon VA Medical Center (VAMC) employees suffered injury due to

Ultraviolet Germicidal Irradiation (UVGI) light overexposure. OIG substantiated the allegation that Operating Room staff were harmed on January 17, 2012, as a result of inadvertent UVGI light overexposure, but the patient was not because he was protected from ultraviolet light exposure by surgical drapes. Affected facility staff suffered temporary blindness, eye irritation, or skin burns. The extent of the overexposure was not known until the following morning when the staff noticed symptoms of overexposure from the UVGI lights. OIG found that facility leadership acted promptly by reporting the incident, notifying and referring employees for care, and disabling the UVGI light switch. OIG did not substantiate the allegation that facility management was previously warned about potential safety hazards from UVGI light overexposure. OIG substantiated the allegation that there were no warning labels on the UVGI light switch. Facility leaders took immediate action to disconnect UVGI lights the same day exposures were reported. OIG made no recommendations. [\[Click here to access report.\]](#)

IG Inspection Finds That Veterans Experience Excessive Wait Times at Memphis VA Emergency Department

OIG reviewed allegations that census in the Emergency Department (ED) at the Memphis VAMC, Memphis, TN, exceeds bed capacity on a regular basis, compromising patient safety; that ED equipment and supplies were inadequate; and that management was unresponsive to these concerns. OIG substantiated that there were significant delays in the ED, but did not find that patients experienced negative outcomes as a result of excessive ED length of stay (LOS). OIG found that the facility's sustained performance for ED LOS is far below the VHA standard. With the exception of availability of ultrasound services, OIG found that ED resources were adequate. OIG found that Emergency Department Integrated Software and Veterans Health Information Systems and Technology Architecture data related to ED LOS times were unreliable. OIG substantiated that management was aware of these issues but had not taken adequate action for resolution. OIG recommended that the Facility Director ensure that actions are taken to reduce ED LOS, increase the availability of ultrasound services for ED patients, and improve the accuracy of ED flow data. The VISN and Facility Directors agreed with the findings and recommendations and provided an acceptable action plan. [\[Click here to access report.\]](#)

Alleged Inadequate Airway Management Unsubstantiated at Muskogee, Oklahoma, VAMC

OIG evaluated allegations of inadequate airway management. OIG did not substantiate the allegation that providers were not competent in airway management. The facility's medical officer of the day (MOD) is responsible for airway management during non-administrative hours. All MODs had documented competence in airway management. OIG did not substantiate the allegation that registered nurses (RNs) intubated outside their scopes of practice. VHA and local policy permit RNs with appropriate training and demonstrated competence to intubate patients in emergent situations outside of the operating room. OIG did not determine that intubation by an RN contributed to a patient's death. An RN intubated a patient at the request and under the supervision of the MOD, and the MOD checked placement of the endotracheal (ET) tube. Although autopsy revealed misplacement of the ET tube, OIG concluded that clinicians exercised

appropriate diligence when they attempted intubation as part of resuscitative efforts and were unable to explain the autopsy finding. OIG did not substantiate the allegation that subsequent to the patient's death, the facility created a policy permitting RNs to intubate. The facility has had an emergency airway management policy in place since November 2005. The local policy, which is consistent with VHA policy, does not preclude RNs from performing ET intubation and airway management in a non-operating room setting. OIG made no recommendations. [\[Click here to access report.\]](#)

Improvement Needed for Access and Coordination of Care at VA Texas Valley Coastal Bend HCS

OIG conducted an inspection to determine the validity of allegations made by a complainant related to access and coordination of care issues at the VA Texas Valley Coastal Bend HCS and the CBOC, both located in Harlingen, Texas. OIG substantiated that patients go to the CBOC for urgent and emergent medical care; cannot be seen in the timeframe requested by the patient or their provider; have difficulty getting medications filled, refilled, or renewed; and that patients experience long wait times at the CBOC. OIG did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients. The VISN and Facility Directors agreed with our findings and four recommendations and provided acceptable improvement plans. [\[Click here to access report.\]](#)

Staffing Ratio Adjustments Needed in Bronx, New York, VAMC

OIG evaluated allegations regarding the Dental Service at the James J. Peters VAMC in Bronx, NY. Specifically, the complainant alleged issues with infection control, oral surgery student oversight, and Dental Service leadership. OIG did not substantiate the allegations of inadequate infection control practices, that the dental clinic had not been thoroughly inspected for years, or that inspections were scripted. OIG did not substantiate or refute that students worked independently in the Oral Surgery Clinic. OIG did not substantiate the allegations of poor or indifferent Dental Service leadership. OIG found that the ratio of dental assistants to practitioners fell short of VHA's recommendations and impacted the work flow and patient volume handled by the clinic. Further, the low dental assistant staffing levels contributed to problems with availability, accountability, supervision, and morale. Therefore, OIG recommended that facility managers assess and adjust staffing ratios for dental assistants to practitioners to bring them into compliance with VHA recommendations. [\[Click here to access report.\]](#)

OIG Determined Appropriate Medication Management at Lincoln, Nebraska, CBOC

OIG conducted a review of the medication management provided for a patient who received health care and prescriptions at the Lincoln CBOC of the VA Nebraska-Western Iowa HCS. The patient died unexpectedly, and a medical examiner determined that the patient's cause of death was accidental multidrug toxicity. The purpose of this review was to determine if the patient received appropriate medication management. The medication management was appropriate. The patient had a complex medical and MH history, which included acute and chronic pain. Providers documented appropriate assessments and evaluations, and considered the risks of

medication, dependency, and side effects. Providers performed medication reconciliations, which included routine reviews of active VA and non-VA medications and the patient's compliance with his medication regimen. Providers monitored the patient for identified potential adverse medication interactions and performed annual blood chemistries, drug levels, and electrocardiograms. OIG made no recommendations. [\[Click here to access report.\]](#)

OIG Releases Annual Report on VA Community Based Outpatient Clinics, Makes 13 Recommendations To Improve Operations

The purpose was to evaluate selected activities, assessing whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. CBOCs overall appear to be providing a quality of care that is not substantially different from parent VAMCs. The CBOCs generally met VHA directives and guidelines. OIG made recommendations affecting Women's Health Liaisons, Computerized Patient Record System, Short-Term Fee Basis local policy, urban CBOCs' outsourcing services, MH emergencies plans, competency assessments, auditory privacy, security of patients' personal information, security vulnerabilities in the allocated Information Technology network space, validation of invoices, contract provisions and acquisition planning, and contractors' awareness of VA standards for coordination of care for MH services. To improve operations, OIG made 13 recommendations to the USH. [\[Click here to access report.\]](#)

Sioux Falls, South Dakota, Benefits Inspection Results

OIG conducted this inspection to evaluate how well the Sioux Falls VARO accomplishes its mission of providing Veterans with access to high-quality benefits and services. OIG found the Sioux Falls VARO staff lacked effective controls and accuracy in processing some disability claims. Overall, VARO staff did not accurately process 21 (31 percent) of the 67 disability claims we sampled. These results do not represent the overall accuracy of disability claims processing at this VARO as we sampled claims we consider at higher risk of processing errors. VARO staff followed Veterans Benefits Administration's (VBA) policy for correcting errors identified by Systematic Technical Accuracy Review staff, as well as effectively completed all Systematic Analysis of Operations. Staff also properly addressed Gulf War Veterans' entitlement to MH treatment and provided outreach to homeless Veterans. However, processing of competency determinations was ineffective. OIG recommended the VARO Director develop and implement a plan to train staff on processing herbicide exposure-related disability claims, as well as implement controls to ensure staff follow current VBA policy on processing competency determinations. The VARO Director concurred with our recommendations. [\[Click here to access report.\]](#)

Inspection Results for VA Clinics in Multiple VISNs

OIG reviewed five CBOCs during the week of April 16, 2012. CBOCs were reviewed in VISN 20 at La Grande and Klamath Falls, OR; Bellevue (King County) and Mount Vernon, WA; and North Bend, OR. 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: 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 34 recommendations to the VISN and facility managers.

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

In a similar review, OIG reviewed four CBOCs during the weeks of May 7–24, 2012. CBOCs were reviewed in VISN 8 at Homestead and Key West, FL; and in VISN 9 at Hopkinsville, KY; and McMinnville, TN. OIG noted opportunities for improvement and made a total of 14 recommendations to the VISN and facility managers.

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

OIG also reviewed four CBOCs during the weeks of May 14– 21, 2012. CBOCs were reviewed in VISN 11 at Mattoon and Springfield, IL; and in VISN 15 at Lawrence, KS; and St. Joseph, MO. OIG noted opportunities for improvement and made a total of 20 recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

Lastly, OIG reviewed four CBOCs during the weeks of May 28 and June 11, 2012. CBOCs were reviewed in VISN 18 at Payson and Show Low, AZ; and in VISN 22 at Long Beach and Laguna Hills, CA. OIG noted opportunities for improvement and made a total of 14 recommendations to the VISN and facility managers.

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

CRIMINAL INVESTIGATIONS

Former Lyons, New Jersey, VAMC Patient Arrested for Overdose Death of Veteran

A former Lyons, NJ, VAMC patient was arrested for administering a lethal dose of heroin to a fellow Veteran and obstructing the investigation into the Veteran's death. An OIG investigation revealed that the defendant and victim purchased heroin outside the medical center and returned to the VAMC, along with a third patient, to take the heroin in the victim's room. The Veteran collapsed while using the drug, and the defendant and third patient departed the room without notifying staff. The victim's body was discovered the next morning. Based on the body's positioning, OIG initially investigated the death as an apparent accidental suicide; however, a confidential source subsequently revealed that the defendant actually administered the heroin to the victim and propped the body to appear as though the victim had taken the heroin and overdosed on his own.

West Palm Beach, Florida, Pharmacy Technician and Other Defendants Sentenced for Drug Possession

A VA pharmacy technician pled guilty to possession of oxycodone and was sentenced to 3 years' probation, 100 hours' community service, and forfeiture of \$180,920. The pharmacy technician's son pled guilty to conspiracy and trafficking oxycodone and was sentenced to 5 years' incarceration with a 3-year mandatory minimum, and a \$53,068 fine. Three other defendants were also sentenced to lesser incarceration times and fines. These sentences stemmed from a 7-month OIG and local drug diversion task force investigation. Operation Tango Vax focused on combating the sale and

distribution of illicit and controlled prescription pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community. The investigation determined that the majority of criminal activity occurred at the VAMC and resulted in the seizure of over 6,000 oxycodone pills and \$180,920.

Former United Parcel Service Employee Indicted for Drug Theft

A former United Parcel Service employee was indicted for theft of Government property. An OIG and local police investigation revealed that from December 2011 to May 2012 the defendant opened VA packages and stole the enclosed medication for personal use. Specifically, the defendant targeted Vicodin, methadone, oxycodone, Oxycontin, hydrocodone and morphine. When confronted, the defendant confessed to his thefts and estimated that he stole approximately 500 pills from 40 to 50 different VA packages.

West Los Angeles, California, VAMC Chief Accountant Charged with Theft of Government Funds

A criminal information was filed against a former West Los Angeles, CA, VAMC chief accountant charging him with theft of Government funds. An OIG investigation revealed that the defendant embezzled \$681,087 of VA funds. To date, \$229,191 of the stolen funds is still missing.

Former Reno, Nevada, VAMC Canteen Service Manager Sentenced for Theft

A former VA canteen service manager was sentenced to 5 years' probation, 100 hours' community service, and ordered to pay \$40,567 in restitution to VA. An OIG investigation revealed that for approximately 18 months the defendant embezzled money from 13 vending machines located at the Reno, NV, VAMC. The defendant consistently under-reported the vending machine sales to conceal the embezzled funds that he used for gambling.

Miami, Florida, Employee Arrested for Credit Card Fraud

A Miami, FL, VAMC employee was indicted and arrested for use or attempted use of unauthorized access device and aggravated identity theft. An OIG and U.S. Secret Service investigation revealed that the defendant used stolen credit card numbers and identities to make online purchases from various retailers using the VA network and computers. The credit card loss is approximately \$9,000.

Veteran Sentenced for Sale of Counterfeit Agency Seals

A Veteran was sentenced to 36 months' incarceration, 36 months' supervised release, and ordered to pay \$43,780 in restitution to over 600 victims for possession and sale of counterfeit U.S. agency seals and impersonating a Federal officer or employee. The defendant was also ordered to abandon all property previously seized by OIG during the execution of a Federal search warrant. A multi-agency investigation, led by OIG, revealed that the defendant was operating an internet printing business that sold counterfeit military awards and training certificates from all military service branches, as well as law enforcement awards and training certificates.

Veterans Indicted for Travel Benefit Fraud

Two Veterans were indicted for bribery, conspiracy to defraud the U.S. Government, and false claims. Previously, five other Veterans and two Seattle, WA, VAMC travel clerks were charged in this case. An OIG investigation revealed that the seven Veterans participated in a scheme, with the VAMC travel clerks, to submit inflated and fictitious travel benefit vouchers. The VA employees processed the vouchers and then demanded kickbacks from the Veterans. The loss to VA is estimated to be over \$150,000.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 6 months' incarceration, 36 months' probation, and ordered to pay \$27,000 in restitution to VA after pleading guilty to theft. An OIG investigation revealed that the defendant submitted approximately 200 fraudulent claims for travel benefits.

Veteran Indicted for Travel Benefit Fraud

A Veteran was indicted for theft of Government funds. An OIG investigation revealed that the defendant filed fraudulent travel benefit claims from November 1998 to April 2012. The defendant claimed that he resided 112 miles from the Bay Pines, FL, VAMC, when in actuality he resided only 6 miles away. The loss to VA is \$57,535.

Federal Contractor Sentenced for SDVOSB Fraud

A Federal contractor was sentenced as a corporation to 3 years' probation and a \$5,000 fine after pleading guilty to wire fraud relating to a \$218,241 Historically Underutilized Business Zone contract. An OIG investigation, conducted with eight other agencies, revealed that the contractor had been part of a fraudulent scheme that involved an additional \$21,511,002 in SDVOSB contracts.

VA Contractor Pleads Guilty to SDVOSB Fraud

A VA contractor pled guilty to conspiracy. A multi-agency investigation revealed that the defendant submitted statements to the Small Business Administration, VA, and other Government agencies falsely representing that a minority and service-disabled Veteran owned and managed the daily operations of a business in order to fraudulently obtain Federal contracts.

Veteran Indicted for VA Compensation Fraud

A Veteran was indicted for theft of Government funds. The defendant had been rated to receive compensation at the 100 percent rate for post-traumatic stress disorder based on her fraudulent reporting to VA that she was housebound and unable to function in society. An OIG investigation revealed that during this time the defendant attended classes, earned degrees in Education, and since 2006 was employed as an elementary school teacher. The loss to VA is \$205,402.

Veteran Arrested for Education Benefits Fraud

A Veteran was arrested after an OIG and local police investigation determined that he forged the signature of his former employer on VA certification forms he submitted for

payment of his education benefits. As a result of these fraudulent submissions, the Veteran received \$9,387 in VA benefits he was not entitled to receive.

Non-Veteran Charged with VA Health Care Fraud

A non-Veteran was charged in a criminal information with theft of Government funds. An OIG investigation determined that the defendant falsely represented himself as a Veteran in order to receive VA health care services. The defendant subsequently received approximately \$32,500 in VA health care benefits.

Former Fayetteville, North Carolina, Compensated Work Therapy Employee Indicted For Theft

A former Fayetteville, NC, compensated work therapy employee was indicted for theft-related violations. An OIG, VA Police Service, and local police investigation revealed that while working in the VAMC's information technology section, the defendant stole several new laptop computers. At least six of the computers were pawned in the local area, and three of those were recovered; however, nine of the stolen computers are still missing. The investigation also revealed that the defendant had an extensive criminal history, including burglary, fleeing custody, and fraud-related charges.

Veteran and Spouse Indicted for Fraud

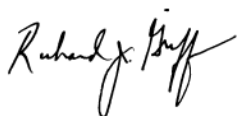
A Veteran and his spouse were indicted for conspiracy, false statements, theft of Government funds, and Social Security Administration (SSA) fraud. A VA OIG, SSA OIG, Federal Bureau of Investigation, and U.S. Air Force investigation revealed that the defendants conspired to fraudulently obtain public money from VA and SSA by providing false statements and documents, which reflected that the Veteran had participated in Special Operations combat duty in Vietnam and Iran while a member of the U.S. Air Force. The loss to VA is approximately \$330,000.

Son of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The son of a deceased VA beneficiary was sentenced to 6 months' confinement in a half-way house, 36 months' probation, and ordered to pay \$46,000 in restitution after pleading guilty to theft of public money. An OIG investigation revealed that the defendant stole VA funds from his deceased mother's bank account after his mother's death in April 2003.

Fugitive Felon Veteran Arrested with Assistance of OIG

A Bonham, TX, VAMC domiciliary resident was arrested by the local police with the assistance of OIG and VA Police Service. The Veteran was wanted on an outstanding warrant for felon in possession of a weapon.



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

GEORGE J. OPFER
Inspector General