2011-03720-IQ-0196

Department of Veterans Affairs

Memorandum

Date: February 16, 2012

From: Assistant Inspector General for Investigations (51)

Subj: Administrative Investigation – Failure of Management to Ensure that Possible Felony Criminal Activity was Promptly Referred to OIG, VA Medical Center, Washington, DC (2011-03720-IQ-0196)

To: Deputy Under Secretary for Health for Operations and Management (10N)

1. The VA Office of Inspector General (OIG) Administrative Investigations Division investigated an allegation that Washington, DC, VA Medical Center Management Officials failed to ensure that possible felony criminal activity was immediately reported to OIG. To assess this allegation, we interviewed Mr. Fernando Rivera, Director of Veterans Integrated Service Network (VISN) 5; Mr. Michael Dunfee, Associate Medical Center Director; Medical Center Police Officials; and other current and former medical center employees. We also reviewed VA Police Uniformed Offense Reports (UOR); Administrative Investigations Board (AIB) and email records; and applicable Federal regulations and VA policy.

2. We concluded that Mr. Rivera and Mr. Dunfee did not always ensure that OIG was immediately notified in cases involving possible or actual felony criminal activities occurring at the medical center. We also found that poor communication between Medical Center Management and Police Officials most likely contributed to the failure to make timely OIG notifications. We noted that the Medical Center Police Service was undergoing a change in leadership and a recertification process and that Mr. Rivera recently took positive steps to ensure that within VISN 5, Medical Center Directors, Associate Directors, and Police Chiefs were aware of the notification requirement and directed them to immediately notify OIG when required. Finally, we found that the local medical center policy did not comply with VA policy in that it lacked specific guidance and reference to making such referrals.

3. We suggest that you emphasize to all Network and Medical Center Directors, as well as other Senior Leaders, to include Associate Directors and Police Chiefs, of the requirement to immediately notify OIG of any possible felony criminal activity. However, we stress that compliance with the obligation to immediately notify OIG does not override the need to contact other local law enforcement as appropriate to the situation for immediate response. Additionally, we suggest that Directors review their local policies and add language that mirrors the notification requirements found in Federal regulations and VA policy. We are providing you this memorandum for your information and official use and whatever action you deem necessary. **No response is necessary.**

4. On April 10, 2003, VA published in the Federal Register a final rule pertaining to the *Referral of Information Regarding Criminal Violations*. The final rule required that VA employees report information about possible criminal activity to appropriate authorities; VA Management Officials report criminal violations occurring on VA property to VA Police; and VA Management Officials to ensure that possible criminal activities involving felonies be promptly referred to OIG. Federal Register, Vol. 68, No. 69, Page 17549, April 10, 2003. VA policy states that criminal matters involving felonies should be immediately referred to OIG, Office of Investigations, and that VA Management Officials are responsible for the prompt referral. It states that felonies include, but are not limited to, theft of Government property over $1,000, false claims, false statements, drug offenses, crimes involving information technology systems, and serious crimes against a person. 38 CFR § 1.204. VA Security and Law Enforcement (SLE) Operations policy requires that each facility publish a standard operating procedure (SOP) for Police and Security Operations [or other similarly titled SOP] that is consistent with Federal laws and VA and VA's SLE policies. VA Handbook 0730, Paragraph 5, (August 11, 2000).

5. In a May 2009 AIB, a clinical Section Chief gave sworn testimony to Medical Center Officials alleging that two physicians covered up shortages of narcotics by falsifying patient records to reflect that the drugs were administered to patients when they were not. The AIB's limited investigative authority did not include investigating these new allegations, so AIB officials, according to their final report, notified Mr. Rivera of the matter 3 days later. We found no records reflecting that Medical Center Management Officials took any action to investigate or refer this matter to OIG. Mr. Rivera told us that he recalled learning of an issue with regards to medication reconciliation; he did not recall this specific allegation; and he could not explain why no action was taken.

6. The Section Chief also told the AIB about a nurse who took narcotics out of the medical center. Email records reflected that this matter was not referred to OIG until almost 1 year later when Regional Counsel became involved to review the matter. Records also reflected that Regional Counsel recognized that the nurse's misconduct required notifying OIG and of Mr. Rivera's reporting requirement. An Assistant Regional Counsel told us that he notified Mr. Rivera about the matter and that Mr. Rivera asked him (Assistant Regional Counsel) to notify OIG. Mr. Rivera told us that he recalled that the nurse took "mixes" out of the medical center; did not realize it involved narcotics; and, he could not recall if he ensured that OIG was notified. He said, "Clearly you have some examples where the IG wasn't notified. But I have thousands in my career where they have been notified."

7. A September 20, 2010, UOR reflected that a burglary and theft of about $12,000 in merchandise occurred at the medical center canteen store and that it was reported to medical center police and management. An OIG Criminal Investigator told us that he learned of the burglary and theft by happenstance on September 23 while visiting the medical center on unrelated business. The Criminal Investigator told us that medical center police failed to preserve some of the physical evidence and that due to a lack of leads, the investigation was later suspended.

8. Another UOR reflected that on May 22, 2011, 8 months later, another burglary occurred at the medical center and that medical center police again conducted an investigation without notifying OIG. OIG eventually learned of this felony crime on May 31, 2010, when an Assistant United States Attorney requested that OIG attend a proffer session involving the suspect. During the proffer session, the suspect also admitted to committing the September 2010 burglary. The OIG Criminal Investigator told us that medical center police never connected the two burglaries and that they did not realize until the proffer session that the suspect was responsible for both. For the second offense, the Police Detective in charge of the investigation admitted that he failed to notify OIG; however, it was unclear what role management played in the notification failure. Mr. Dunfee told us that at the time these burglaries occurred, he was unfamiliar with the requirement to immediately notify OIG and as such, he said that he never thought to ensure that notifications were made.

9. In yet another example, the Medical Center Compliance and Business Integrity Officer (CBIO) told us that she initiated an internal investigation after receiving an allegation that a contractor employee falsified timecards. Although the timecards were in her possession for several weeks, she never questioned whether the signatures were valid, until just before she and Mr. Dunfee notified VA police. Email records reflected that on July 29, 2011, Mr. Dunfee told medical center police of their internal investigation, after they realized that the employee forged signatures of identified VA Officials before submitting the timecards to the contractor for payment. Email records reflected that the loss to VA was estimated to be around $50,000. Records also reflected that once notified, medical center police began an investigation; however, they did not notify OIG until August 5. The UOR reflected that medical center police interviewed the contractor employee, who confessed to falsifying and forging the timecards. The Detective told us that after the interview, he allowed the employee to leave without making an arrest, without contacting OIG, or without seeking guidance from the United States Attorney's Office. The OIG Criminal Investigator told us that the contractor employee did not return to work and was never heard from since.

10. The Detective told us that Mr. Dunfee directed medical center police not to notify OIG concerning this matter, and in a July 29, 2011, email, the former Medical Center Police Chief told the Detective that Mr. Dunfee "...doesn't want to notify the IG yet, so just keep this to yourself." Mr. Dunfee told us that the Chief Financial Officer told him about the suspected timecard fraud early on and that he knew that the CBIO was investigating the matter. Mr. Dunfee said that he never told the CBIO not to notify medical center police and that he did not recall telling anyone not to notify OIG. He said that it was possible that he wanted to delay notifying OIG until he had an opportunity to notify "everyone up the chain of command."

11. The Detective told us that the medical center failed an inspection, resulting in the former Police Chief being removed from his position, and Mr. Rivera told us that they were recruiting for a new Police Chief and undergoing a recertification process. In addition, on December 14, 2011, Mr. Rivera sent an email to all Medical Center Directors, Associate Directors, and Police Chiefs within the VISN informing them

about the requirement to immediately notify OIG of possible felony criminal activities, and he directed his staff to make sure that they complied with those requirements.

12. In addition, we found that the Washington, DC, VA Medical Center policy did not comply with VA policy. It stated in part, "On all deaths where there is a possibility that there may be a crime scene...the VA Police will be notified immediately...notify the Federal Bureau of Investigations and the Metropolitan Police Department." The policy not only did not contain language requiring the notification of OIG of any possibly felony criminal activity but it did not require notifying OIG in cases of a death resulting from a crime.

Conclusion

13. We concluded that Mr. Rivera and Mr. Dunfee did not always ensure that OIG was immediately notified in cases involving possible or actual felony criminal activities occurring at the medical center. We also found that poor communication between Medical Center Management and Police Officials most likely contributed to the failure to make timely OIG notifications. We noted that the Medical Center Police Service was undergoing a change in leadership and a recertification process and that Mr. Rivera recently took positive steps to ensure that within VISN 5, Medical Center Directors, Associate Directors and Police Chiefs were aware of the notification requirement, directing them to immediately notify OIG when required. However, we found that the local medical center policy did not comply with VA policy in that it lacked specific guidance and reference to making such referrals.

14. We suggest that you emphasize to all Network and Medical Center Directors, as well as other Senior Leaders, to include Associate Directors and Police Chiefs, of the requirement to immediately notify OIG of any possible felony criminal activity. However, we stress that compliance with the obligation to immediately notify OIG does not override the need to contact other local law enforcement as appropriate to the situation for immediate response. Additionally, we suggest that they review their local policies and add language that mirrors the notification requirements found in Federal regulations and VA policy. We are providing you this memorandum for your information and official use and whatever action you deem necessary. It is subject to the provisions of the Privacy Act of 1974 (5 USC § 552a). You may discuss the contents of this memorandum with Mr. Rivera, Mr. Dunfee or VA Police Officials, within the bounds of the Privacy Act; however, it may not be released to them. If you have any questions, please contact (b) (7)(C) [redacted]

(b) (7)(C) [redacted]

(b) (7)(C) [redacted]