Office of Inspector General

Semiannual Report to Congress

April 1, 2000 – September 30, 2000

FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended September 30, 2000. The OIG is dedicated to help ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

Most significant in the protection of veterans was the prosecution of Dr. Michael Swango. After a 7-year investigation by our Office of Investigations, with assistance by our Office of Healthcare Inspections, Swango pleaded guilty in Federal court to the murder of three veterans under his care at a VA medical center (VAMC). He also admitted to the murder of a 19-year-old patient at a university hospital in 1984. Swango was sentenced to three consecutive life terms in prison with no possibility of parole.

Our criminal investigations continue to target cases of public corruption and major thefts, instances where incapacitated veterans fall victim to unscrupulous individuals, and fraud involving programs for the delivery of benefits to veterans. We place a priority on safety and security at VA medical centers. Allegations of fraud demand an immediate response. The OIG will take decisive action against those who prey on veterans and will hold accountable those VA employees who disregard their public trust responsibilities. During the period, OIG criminal and administrative investigations yielded 174 arrests, 156 indictments, 122 criminal convictions, and 195 administrative actions, foremost of which were cases involving fraud and employee misconduct.

Our oversight of VA, the second largest Department in the Federal Government, covers medical care, benefits administration, procurement, financial management, facilities management, and information technology. The audits and evaluations focused on determining how programs can work better, while improving service to veterans and their families. OIG audits, investigations, and other reviews identified over $54 million in monetary benefits. For example, an audit presented opportunities to reduce pharmaceutical inventories by over 59 percent or $31 million. Monetary benefits of this type can be redirected to programs that can improve or increase services to veterans. In addition, a noteworthy accomplishment was our evaluation of security controls for VA automated data processing systems that identified a number of significant control weaknesses and provided several recommendations for enhancing security of the systems tested.

Since VA operates the largest health care system in the United States, the focus of OIG Healthcare Inspections is on quality of care issues. This includes a proactive review of the Veterans Health Administration's (VHA's) patient safety program. Healthcare inspectors also oversee VHA's Office of Medical Inspector activities and review the adequacy of VA's responses to allegations of inadequate health care management and patient care.

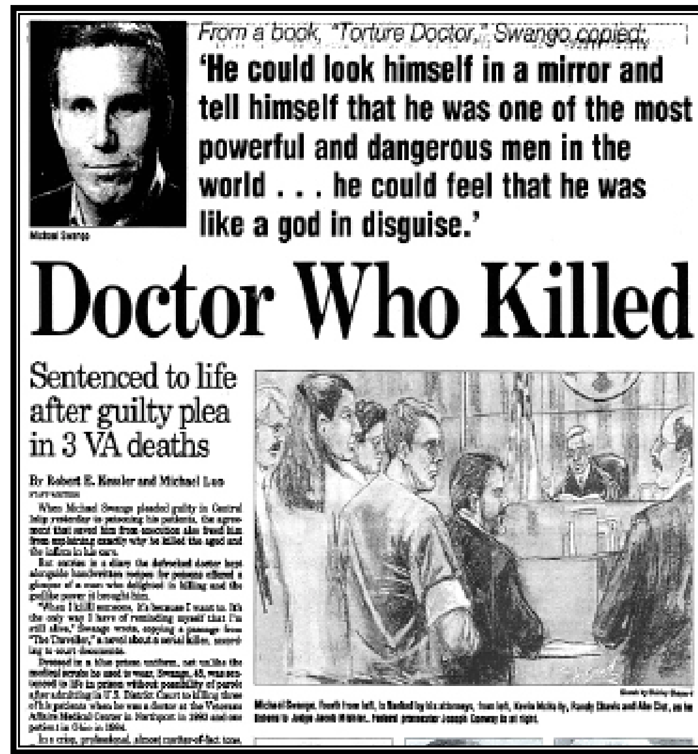
The OIG's ongoing Combined Assessment Program (CAP) evaluates the quality, efficiency, and effectiveness of VA facilities. Through this program, auditors, investigators, and healthcare inspectors collaborate to assess key operations and programs at VAMCs on a cyclical basis. The 14 CAP reviews completed during this 6-month reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention. Through increased or restructured resources, I am committed to extending this program to enable more frequent oversight of VA activities.

I look forward to continued partnership with the Secretary and the Congress in improving service to our Nation's veterans.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

INSPECTOR
GENERAL

VA OIG CASE OF 2000



From a book, "Torture Doctor," Swango copied:

'He could look himself in a mirror and tell himself that he was one of the most powerful and dangerous men in the world . . . he could feel that he was like a god in disguise.'

Doctor Who Killed

Sentenced to life after guilty plea in 3 VA deaths

By Robert E. Kessler and Michael Luo

For 7 years, VA OIG agents and healthcare inspectors, along with the Office of the U.S. Attorney and the FBI worked to put Dr. Michael J. Swango permanently behind bars. On September 7, 2000, Swango pleaded guilty to the murder of three veterans in his care at VA Medical Center (VAMC) Northport, NY. He was sentenced to three consecutive life terms without the possibility of parole for the VAMC murders.

The Ohio Murder and Assault

Michael Swango graduated from the Southern Illinois University Medical School in 1983 and began the internship program at Ohio State University Hospital upon his graduation. As spelled out in the indictment, while working as an intern at Ohio State University Hospital in January 1984, Dr. Swango murdered Cynthia McGee by injecting her with a lethal dose of potassium. In February 1984, he assaulted his patient, Rena Cooper, by injecting her with a poisonous substance. She survived the attack. After that assault, Ohio State University Hospital removed Dr.

Swango from the residency program, and in 1985 Ohio authorities commenced a murder investigation into his activities. Although that investigation did not result in the filing of charges against Swango, he did learn of the investigation and concealed the fact that he was investigated for murdering patients from the other hospitals that subsequently hired him.

Adams County Ambulance Service

In 1985, Swango began employment at the Adams County, Illinois, Ambulance Service as an emergency medical technician. According to the indictment, he poisoned several of his co-workers there with arsenic. They later recovered and he was tried and convicted of aggravated battery. He was sentenced to a 5-year term of imprisonment.

Northport Murders and Assault

Several years after his release from an Illinois prison, Swango sought admission to several medical residency programs. In 1992, he was hired by the University of South Dakota and assigned to work as a resident at the VAMC Sioux Falls, South Dakota, after he falsified facts about his prior criminal conviction. Swango was discharged from the program after hospital administrators became aware of the facts surrounding his conviction and his activities at Ohio State University Hospital.

In 1993, Swango applied for and obtained a position as a medical resident at the State University of Stony Brook Medical School, which ran a residency program at VAMC Northport. During the application process, he misrepresented that his criminal conviction in Illinois stemmed from a barroom brawl; a false statement that ultimately led to his conviction and incarceration on Federal charges.

Thereafter, Swango murdered George Siano, Aldo Serini and Thomas Sammarco, while all three were patients at VAMC Northport. Swango killed all three patients by administering injections of toxic substances. In addition, Swango also injected a poison into another patient at the hospital, Barron Harris. Mr. Harris survived the incident.

In October 1993 Swango was discharged from his residency at VAMC Northport, and was later charged with making a false statement to Federal officials and improper use of controlled substances in connection with his employment there. Before those charges were filed

VA OIG, FBI and Federal Prosecutors speak to the press outside the U.S. District Court House in Central Islip, NY following the conviction of Dr. Michael Swango for the murder of three veteran patients at the Northport VA Medical Center.

however, he fled the United States and was hired as a physician at the Zimbabwe Association of Church Hospitals.

The Zimbabwe Assaults

On May 14, 1995 and July 7, 1995, respectively, Swango administered injections of toxic substances into his patients Kenias Mueaza and Virginia Sibanda, both of whom were under his care at Mnene Hospital in Zimbabwe, Africa. Both survived Swango's attacks. Swango was suspended from practice at Mnene Hospital in July 1995.

Saudi Arabia

In 1997, as a result of false statements, Swango obtained employment as a physician through KAMA Enterprises, Inc., an employment agency in Portland, Oregon, and was assigned to work as a physician at the Royal Hospital in Dharan, Saudi Arabia. In June 1997, Swango was arrested in a Chicago airport on his way from Africa to Saudi Arabia, to begin his employment there. He was arrested for the false statement and controlled substance charges that had been filed in the Eastern Judicial District of New York.

Making the Case

While Swango was imprisoned on this charge, VA OIG investigators and healthcare inspectors, FBI agents, and U.S. Attorneys had limited time to find the evidence to make the case for the three deaths which happened in a federal facility. Extensive review of records, laboratory studies, and interviewing witnesses in the United States and Africa took thousands of hours. In that effort, the team received the full cooperation and support from the management and staff at VA Medical Center Northport, NY.

The Guilty Plea and Sentence

Faced with the possibility of a death sentence, Swango pleaded guilty to the murder of the three veterans in New York and was sentenced to three consecutive life terms without parole.

VA IG Richard Griffin and U.S. Attorney Loretta Lynch

"Through a web of lies and deception, Michael Swango inveigled his way into the confidence of hospital administrators across the country and the world. Once in their trust and employ, he utilized his skills to search for victims and take their lives. This case is the result of the hard work and diligent efforts of not just this office but of the Federal Bureau of Investigation and the Department of Veterans Affairs Office of Inspector General, who were determined that Swango be held accountable for his actions and not be allowed to victimize others. I thank both of those agencies for their dedication and determination in investigating this matter, across the years and the globe. We extend our deepest sympathies to the victims and their families."

Loretta E. Lynch
United States Attorney

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HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended September 30, 2000. The following statistical data highlights OIG activities and accomplishments during the reporting period.

	Current 6 Months 4/1/00 – 9/30/00	FY 2000 10/1/99 – 9/30/00
DOLLAR IMPACT	Dollars in Millions	
Funds Put to Better Use	$41.7	$302.2
Dollar Recoveries	$6.0	$11.4
Fines, Penalties, Restitutions, and Civil Judgments	$7.2	$13.8
RETURN ON INVESTMENT		
Dollar Impact ($54.9) / Cost of OIG Operations ($24.6)	2 : 1	
Dollar Impact ($327.4) / Cost of OIG Operations ($45.4)		7 : 1
OTHER IMPACT		
Arrests	174	338
Indictments	156	280
Convictions	122	247
Administrative Sanctions	195	496
ACTIVITIES		
Reports Issued		
Combined Assessment Program	14	18
Audits	19	35
Contract Reviews	24	40
Healthcare Inspections	9	15
Administrative Investigations	8	16
Investigative Cases		
Opened	478	882
Closed	316	545
Hotline Activities		
Contacts	8,319	15,771
Cases Opened	547	985
Cases Closed	461	717

OFFICE OF INVESTIGATIONS

Overall Focus

During the semiannual period, the Office of Investigations focused its resources on investigations that have the highest impact on the programs and operations of the Department. Criminal investigative

priority continues to target cases of public corruption, procurement fraud, healthcare fraud, instances where incapacitated veterans fall victim to unscrupulous fiduciaries, and fraud involving programs for the delivery of benefits to veterans. Emphasis has also been placed on safety and security at VA medical centers (VAMCs) and a strong working relationship has been developed with the VA Office of Security and Law Enforcement along with VA police throughout the nation. Immediate response to criminal allegations is absolutely essential and demonstrates that the OIG will take decisive action against those who prey on veterans and will hold accountable those VA employees who disregard their public trust responsibilities.

Results

During the period, the Criminal Investigations Division concluded 316 investigations resulting in 278 judicial actions and over $13.9 million recovered or saved. Investigative activities resulted in the arrests of 174 individuals who had committed crimes involving VA programs and operations or on VA facilities. In addition, the division realized monetary benefits of approximately $9 returned or saved by the Government for each dollar spent. The Administrative Investigations Division concentrated its resources on investigating allegations against high-ranking VA officials concerning misconduct and other matters of interest to the Congress and the Department. The division completed 22 administrative investigations this period and issued 8 reports. These investigations resulted in administrative action taken against 11 high-ranking officials and other employees, and 7 corrective actions taken by management to improve VA operations and activities.

Veterans Health Administration (VHA) and Veterans Benefit Administration (VBA)

The Office of Investigations, working hand-in-hand with VA police, assisted in over 40 arrests of individuals who committed crimes at VAMCs. Over 300 investigations were initiated in the benefits fraud area of individuals that were fraudulently diverting VA funds. This period brought the conclusion to many investigative cases which led to significant results. A former VA employee was sentenced to 25 years in prison after admitting to stealing drugs and video equipment from a VA hospital. He used the equipment to videotape himself in sexual acts with underage children whom he had knocked out with stolen drugs. In another high profile investigation, a pastor of a church pleaded guilty to stealing over $118,000 in VA funds. The individual diverted the funds, earmarked for a homeless veteran project, to a real estate business that he operated. Most significant was the completion of a 7-year investigation resulting in guilty pleas by Dr. Michael Swango to three counts of murder and two counts of fraud.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $40.6 Million

Audits and evaluations were conducted which focused on determining how programs can work better, while improving service to veterans. During this reporting period, 33 performance, financial, and Combined Assessment Program (CAP) audits, evaluations, and reviews, as well as 24 contract reviews identified opportunities to save or make better use of $40.6 million. The Office of Audit returned $3 for every dollar spent on performance and financial audits. Contract reviews returned $8 in monetary benefits for every dollar spent.