OFFICE OF AUDITS & EVALUATIONS



# Inspection of VA Regional Office Wilmington, DE

# Office of Inspector General Benefits Inspection Program

The Benefits Inspection Program is part of the Office of Inspector General's (OIG's) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to the improvement and management of benefits processing activities and veteran services by conducting onsite inspections at 57 VA Regional Offices. The purpose of these independent inspections is to provide recurring oversight of VA Regional Offices by focusing on disability compensation claims processing and performance of Veteran Service Center operations. The objectives of the inspections are to:

- Evaluate how well VA Regional Offices (VAROs) and Veteran Service Centers (VSCs) are accomplishing their missions of providing veterans convenient access to high quality benefit services.
- Determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VSC operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4:00PM Eastern Time,

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# Report Highlights: Inspection of VA Regional Office, Wilmington, DE.

## Why We Did This Review

The Benefits Inspection Program conducts on-site inspections at VA Regional Offices to review disability compensation claims processing and Veteran Service Center operations.

#### What We Found

The Wilmington Regional Office management team met the requirements for processing benefit claims involving traumatic brain injury. The office also met all requirements in the areas of systematic analysis of operations (SAOs), correcting Systematic Technical Accuracy Review (STAR) errors, date stamp accountability, implementation of the Claims Process Improvement model, handling claimsrelated mail, and responding to electronic inquiries.

The Regional Office management team needs to provide additional management attention in processing claims identified as Haas cases, post traumatic stress disorder, and diabetes. The management team also needs to improve controls over the following areas:

- Safeguarding veteran's personally identifiable information (PII).
- Responding to congressional inquiries.
- Processing fiduciary activities.

- Tracking veteran's claims in Control of Veterans Records System (COVERS).
- Establishing the correct dates of claim.

#### What We Recommend

We recommended that the VARO provide refresher training on claims-processing and improve management oversight and controls over operations.

## **Agency Comments**

The Director of the Wilmington Regional Office concurred with all recommendations. Management's planned actions are responsive and we will follow-up as required on all actions.

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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# **Results of Inspection**

During the week of May 26–29, 2009, the OIG conducted an inspection of the Wilmington VA Regional Office (VARO). The inspection focused on 5 protocol areas examining 15 operational activities. The VARO did not meet the requirements for 8 of the 15 operational activities inspected. (See Appendix A for a description of the protocol areas and operational activities reviewed.) We also made observations pertaining to issues that are not specifically required by VBA policy or procedure but still affect benefits delivery or VARO performance and provide an opportunity to improve operations.

## **VARO Activities Needing Additional Management Attention**

## Disability Claims Processing

We reviewed 61 (82 percent) of 74 completed Haas<sup>1</sup> cases, post traumatic stress disorder (PTSD), traumatic brain injury (TBI), and diabetes claims for which the VARO made a decision regarding specified issues. The claims decisions were made during the time period of January 1, 2009, through March 31, 2009. The 61 claims represent 100 percent of Haas, PTSD, TBI, and diabetes claims completed and available for review at the Wilmington VARO during that time period.

Our analysis revealed errors in 7 (11 percent) of the 61 claims. Only 4 (7 percent) of the 61 claims with errors were processed at the Wilmington VARO. The three remaining errors were attributable to processes completed at other VAROs. Regardless of where claims decisions are processed, these errors negatively impact the delivery of benefits to veterans. For example, the three claims processed at other VARO's contained errors that impacted veterans' benefits. The following table reflects the errors by claim type and those errors impacting veteran's benefits:

**Table 1. Disability Claims Processing Errors** 

Claim Type	Claims Reviewed	Claims With Errors	Errors With Impact On Veteran Benefits	Claims Processed At Another VARO Containing Errors
Haas	5	1	1	0
PTSD	22	5	4	3
TBI	3	0	0	0
Diabetes	31	1	1	0
Total	61	7	6	3

<sup>&</sup>lt;sup>1</sup>A Haas claim is a claim affected by a U.S. Court of Appeals for Veterans Claims decision in *Haas v. Nicholson*. Haas claims involve veterans who served in waters off Vietnam and did not set foot in Vietnam, potentially precluding those veterans from entitlement to presumption of exposure to herbicide agents, including Agent Orange. VA put a stay of adjudication on these claims; however, it lifted the stay in January 2009.

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# VSC personnel made inaccurate disability decisions processing Haas, PTSD, TBI, and diabetes claims.

<u>Haas Claim</u>. The processing error identified for the Haas case impacted the veteran's benefits. The VARO staff incorrectly identified this claim as a Haas claim. In November 2008, the VARO received information confirming the veteran's presence in Vietnam. At that time the VARO should have removed the Haas designation and completed processing the claim. The claim was unnecessarily delayed by 7 months.

<u>PTSD Claims</u>. Four of the five processing errors identified for PTSD cases impacted veterans' benefits. For example:

- A veteran did not receive the appropriate disability evaluation based on medical evidence provided in the VA examination.
- VARO staff did not address the issue of competency for a 100 percent service-connected veteran. VBA policy requires consideration of incompetency for any mental disability evaluated as 100 percent disabling.
- Service connection was incorrectly established for depression. The claims folder did not contain medical evidence showing the veteran had a diagnosis of depression.
   VARO staff should have denied the claim.
- VARO staff prematurely denied service connection for PTSD based on the lack of a verifiable stressful event. The veteran provided sufficient evidence to allow a thorough search to verify the veteran's allegation.

The remaining error was procedural in nature as Veterans Service Center (VSC) staff recorded the incorrect date of claim in the electronic record. No impact to the veteran occurred as no benefits were granted.

<u>Diabetes Claim</u>. The processing error identified for diabetes impacted the veteran's benefits because VARO staff failed to grant the correct effective date to pay benefits. The veteran was entitled to a one-month retroactive payment due to liberalizing legislation.

The processing errors for Haas, PTSD, and diabetes claims occurred due to unintentional human error. Senior VSC management raised the concern that most of the new RVSRs had less than 3 years experience. As a result, some disability decisions were inaccurate in that veterans were not always granted service connection or received incorrect benefit payments. Senior VSC management agreed with the identified errors in Haas, PTSD and diabetes claims and took immediate action to correct those errors.

**Recommendation 1.** We recommend the Wilmington VA Regional Office Director ensure refresher training is scheduled and emphasizes the correct procedures for processing Haas, post-traumatic stress disorder, and diabetes claims for Veteran Service Center personnel.

#### **Management Comment**

The VARO Director concurred with the recommendation and provided remedial training emphasizing the correct procedures for processing Haas, PTSD, and diabetes claims.

#### **OIG Response**

Management comments and actions are responsive to the recommendation.

## **Management Controls**

We assessed management controls to determine if the VARO management team adhered to VBA policy regarding employee rotations within the Claims Process Improvement (CPI) business model, correcting errors identified by the Systematic Technical Analysis Review (STAR) staff, completing Systematic Analysis of Operations (SAOs), and ensuring VARO date stamp accountability.

The Wilmington VARO management team met the requirements and rotated employees within the CPI business model, corrected STAR errors, completed SAOs, and properly accounted for and safeguarded date stamps. The VARO followed its plan to rotate Veterans Service Representatives (VSRs) within the CPI business model annually. Also, the VSC completed the mandatory SAOs and timely corrected all errors identified by the STAR staff. In addition, we observed that the VARO properly maintained an accountability log for all electronic date stamps and all date stamps were secured at the end of every business day.

## Information Security

The OIG inspection team conducted random inspections of employee workstations to determine if staff properly followed VBA policies to safeguard veterans' personally identifiable information (PII). We also analyzed mail-handling procedures in the VARO mailroom and the VSC Triage team to ensure the accurate and timely processing of mail. VARO Wilmington processed mail daily as required by VA mail handling procedures.

The VARO needs to improve safeguards over veterans' personally identifiable information. During random inspections of the VARO storage area for document shredding, we observed an unlocked door and later determined the locking mechanism was broken. We could not determine how long the door lock had been broken and senior management was unaware of this problem. Management notified building maintenance, which repaired the locking mechanism while the inspection team was onsite.

Inside the room, we identified two shred bins completely full of documents identified by VARO staff for shredding. Although documents were properly signed off for shredding and both shred bins were locked, each had a slot on top of the shred bin large enough for one of the inspectors to retrieve documents without difficulty. In addition, the designated storage room also served as the information technology (IT) office for the VARO. This office contained the network server for the entire VARO. Several employees had access to this office to include IT staff and a Decision Review Officer.

VBA policy<sup>2</sup> clearly states "access to shredders, shredder bins, or other methods of document destruction will be strictly controlled and limited to senior management, Records Management Officers (RMO), and Division Records Management Officers (DRMO) at all VBA locations." Neither of the aforementioned employees was designated as senior management, a RMO or a DRMO.

We also found PII at two employees' desks that were not redacted training material. In addition, we found documents inside one desk that contained veteran's PII on a congressional inquiries log.

As a result of the broken door lock and uncontrolled access to materials designated for destruction, the Veterans Service Center Manager (VSCM) lacks assurance that veteran's personally identifiable information is properly safeguarded.

**Recommendation 2.** We recommend the Wilmington VA Regional Office Director develop and implement a mechanism to ensure only authorized staff have access to materials designated for destruction.

#### **Management Comment**

The VARO Director concurred with the recommendation and has limited employee access to shred bins to the VSCM, Supervisor Veterans Service Representative, and DRMO by combination lock. In addition, the VARO has purchased an additional shred bin and repaired the locking mechanism to the storage area.

#### **OIG Response**

Management comments and actions are responsive to the recommendation.

#### **Public Contact**

The Public Contact team provides benefit information to veterans, beneficiaries, and congressional staff through several methods including e-mail and written correspondence. We reviewed VA's Inquiry Routing and Information System (IRIS) and congressional

VA Office of Inspector General

<sup>&</sup>lt;sup>2</sup>VBA letter 20-08-63, VBA Policy on Management of Veterans' and other Governmental Paper Records, revised March 13, 2009.

inquiries for accuracy and timeliness of the responses. In addition, we inspected Fiduciary Program activities to determine if VA designated fiduciaries are properly managing VA and personal funds of veterans who are unable to do so.

The Wilmington VARO generally met the requirements to timely and accurately process IRIS inquiries. One (less than 3 percent) of the 34 files reviewed was not accurately processed and two (6 percent) of the 34 responses were not timely processed.

Controls over the processing of congressional inquiries need strengthening. The VARO management reported one formal written congressional inquiry was completed during the second quarter FY 2009. This inquiry was accurately completed and processed within VBA's 5 day standard.

In addition to the formal written inquiry, a VARO hand written log contained 43 congressional inquiries received via e-mail and telephone during the time period of January 1, 2009, through March 31, 2009. We found the entries in the log were not always legible and did not contain information such as date the inquiry was completed, the nature of the inquiry, and the VARO's response to congressional staff. Since the congressional log did not contain the response date, the VSC has no assurance these inquiries were completed within VBA's goal of providing responses in 5 days. Without this information, the VARO and we were unable to evaluate the timeliness and accuracy of their congressional inquiry program.

In addition, VARO staff do not place completed congressional inquiries into the veteran's claim folder. VBA policy states any correspondence that requires a reply must be filed in the veteran's record. Failure to place the congressional inquiry in the folder precludes the veteran from obtaining a complete copy of documents in the folder under the Freedom of Information Act. Also, VSC staff would be unaware if members of Congress have requested additional information for a specific case.

**Recommendation 3.** We recommend the Wilmington VA Regional Office Director develop and implement a mechanism to ensure the Veteran Service Center processes congressional inquiries according to VBA policy.

#### **Management Comment**

The VARO Director concurred with the recommendation and developed a mechanism to properly document and control correspondence related to congressional inquiries.

#### **OIG Response**

Management comments and actions are responsive to the recommendation.

Controls over fiduciary activities need strengthening. The Philadelphia VARO maintains responsibility for processing all Fiduciary cases for the Wilmington VARO. Therefore, no full-time Fiduciary employees are assigned to Wilmington. However, VBA holds Wilmington responsible for all national performance measures associated with Fiduciary claims processed where the beneficiary resides in the state of Delaware. The Philadelphia VARO has assigned an Assistant Veterans Service Center Manager (AVSCM) to provide oversight of VARO Wilmington fiduciary activities.

Analysis of 15 Principal Guardianship Folder (PGF) cases that were completed during April 1, 2009, through May 19, 2009 found processing errors in the following type of fiduciary activities:

- Initial Appointments (IA)—IA field examinations involve the qualification and appointment of a fiduciary to receive VA benefits on behalf of an incompetent beneficiary.
- Fiduciary Beneficiary (FB)—Follow-up field examinations involve the reassessment of incompetent veterans' needs and determines whether funds have been properly used and protected. The first FB must be completed within one year of the initial appointment. Subsequent FBs are determined by the field examiner's assessment of the current status of the beneficiary and the fiduciary.
- Accountings—Fiduciary's written report of the management of a beneficiary's income and estate.

Our analysis revealed all 15 PGFs were not processed according to VBA policy. Table 2 below reflects the number of errors by claim type and those errors that impact veteran's benefits (see Appendix C for a summary of the errors and relevant policy):

Claim Type	Number Reviewed	Number in Error	Errors With Impact On Veterans' Benefits
Initial Appointment (IA)	8	8	2
Fiduciary Beneficiary (FB)	5	5	1
Accountings	2	2	1
Total	15	15	4

**Table 2. Fiduciary Processing Errors** 

Following is a description of errors that may impact the safeguarding of incompetent veterans' benefits:

#### **Initial Appointments (IA):**

• 1 IA—No verification of beneficiary's funds on deposit with the fiduciary and no verification of current monthly expenses.

• 1 IA—Fiduciary's criminal background not thoroughly assessed prior to certifying the fiduciary to provide direction and supervision of VA benefits.

#### Fiduciary Beneficiary (FB):

• 1 FB—Fiduciary unit not properly monitoring fiduciary's use of beneficiary funds as surplus funds not properly discussed and increases in expenses not justified.

#### **Accountings:**

• 1 Accounting—Fiduciary unit did not document beneficiary's account balance and did not provide interest earned for correct accounting period.

In addition to errors affecting benefits, all 15 files reviewed contained one common error. The Fiduciary Unit was not using the correct date stamp on documents received. VBA policy requires documents processed by fiduciary units to be stamped with a date stamp clearly identifying the date and location, such as "Fiduciary Unit," reflecting the documents were received in the Fiduciary Unit. In addition to timeliness and performance issues, mail received for filing in PGFs may be pertinent if the record is reviewed for consideration of an administrative error or called into court under a subpoena. The date that the documents were physically received is necessary to support the date VA had notice of the action or event.

The AVSCM did not agree with these errors noting "the manual needs to be clearer regarding proper use of date stamps." The inspection team interviewed Compensation and Pension Service's Assistant Director of Veterans Services. The Assistant Director indicated this is absolutely an error if documents received in the fiduciary unit are not stamped with a unique date stamp indicating the date and Fiduciary Unit. VBA's STAR also identified similar errors at VARO Wilmington during FY 2009. Based on our analysis of the aforementioned errors and the interview with the AVSCM, we feel these errors occurred because of inadequate training.

**Recommendation 4.** We recommend the Wilmington VA Regional Office Director provide training to Legal Instrument Examiners and Field Examiners on processing Initial Appointments, Fiduciary Beneficiaries, and Accountings as required by VBA policies and procedures.

#### **Management Comment**

The VARO Director concurred with our recommendation and provided training on June 2, 2009, and again July 14–July 15, 2009.

#### **OIG Response**

Management comments and actions are responsive to the recommendation.

## Data Integrity

We assessed data in VBA's Control of Veterans Records System (COVERS) to determine if the VARO is accurately tracking the location of veterans' claims folders. The primary function of COVERS is tracking the location of claims folders within, and between VAROs. COVERS also supports VARO claims folder activities such as requesting folders and identifying mail to associate with folders.

In addition, we reviewed claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claim in the electronic record. The date of claim is generally used to indicate when a document arrives at a specific VA facility. VBA relies on an accurate date of claim to establish and track a key performance measure to determine the average days to complete a claim.

VSC policy to track the location of veterans' claims folders was not enforced. Our review of 30 disability claims to determine if VSC staff consistently tracked veterans' claims folders revealed 14 (47 percent) of the 30 claims had not been adequately tracked in COVERS. Local policy states COVERS will be updated every Friday. In addition, 8 (57 percent) of the 14 files had not been input into COVERS within 30 days. Senior VSC management stated non-compliance with VSC policy was due to a lack of oversight. As a result, management is unsure of the location of all claims folders within the VSC. Ultimately, management lacks assurance that claims-related mail has been properly associated with the correct claim folder.

**Recommendation 5.** We recommend the Wilmington VA Regional Office Director establish and implement a mechanism to ensure Veteran Service Center staff uses Control of Veterans Records Systems as required by established policies.

#### **Management Comment**

The VARO Director concurred with the recommendation and stated the COVERS day would be strictly enforced. The VARO Director reissued a memorandum to all employees reemphasizing the designation of every Friday as the date employees will ensure all claims folders are COVER'd to the appropriate location.

Although the Regional Office (RO) concurred with the recommendation, the Director offered comments regarding the nature of the errors. The Director told us errors involved cases that were properly COVER'd to their current locations; however, the errors were identified because they had not been re-COVER'd on the last designated COVERS day.

#### **OIG Response**

Management comments and actions are responsive to the recommendation. The VARO Director is correct in stating the errors generally involved cases properly COVER'd to the

appropriate locations. However, the VARO Director supports our position, as RO staff did not follow local policy to re-COVER files on the designated day (an average of 39 days).

#### VSC staff did not always establish the correct date of claim.

We selected 30 disability claims to determine if VSC staff established the correct date of claim in the electronic record. Our analysis revealed 2 (7 percent) of the 30 claims contained the incorrect date of claim. However, we saw no evidence indicating the incorrect dates of claim were established with intent to inappropriately improve VARO performance standards. VARO management corrected the deficiencies prior to completion of the site inspection.

#### **Observations**

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related issues. Several observations were noted during the onsite inspection:

• Workload Credit for Unfinished Claims. The Wilmington VARO took credit for completing fiduciary claims for 10 (77 percent) of the 13 IA and FB files reviewed prior to all work associated with those claims being finished. VBA policy states "work should be completed as soon as practical." This policy does not clearly outline a specific standard as to when the work credit should be taken or if all work associated with a fiduciary claim must be completed prior to taking credit for completing the claim. For example, VARO Wilmington took work credit for one claim, however, work continued on that claim for an additional 14 days.

The work on the claims was ultimately completed. We are providing this observation as a practice to be aware of because once the work credit has been taken, there is no control to ensure the completion of additional internal actions associated with fiduciary estate administration. Furthermore, senior VBA leadership does not receive accurate information relating to the actual time required to complete fiduciary claims.

• Brokered Claims. VBA has established a brokering plan that allows VAROs to send (broker) claims that are designated as ready-to-rate to other VAROs for processing. VAROs that broker claims typically do not have the rating capacity to complete such work in a specific time. VARO Wilmington brokered 175 rating-related claims to other VAROs for processing from March 2009 through May 2009. During our review of claims processing, three of the claims were brokered to other VAROs and all contained errors impacting veteran's benefits.

In March 2009,<sup>3</sup> we reported that the STAR quality assurance process does not provide a complete assessment of compensation claim rating accuracy, partially because it excluded brokered claims from STAR reviews. The accuracy of brokered claims was 18 percent lower than the national accuracy VBA reported for the 12-month period ending February 2008 in *VA's FY 2008 Performance and Accountability* report. VBA agreed to establish procedures for reviewing quality of brokered claims in response to the audit recommendations. However, until those procedures are in place, brokered claims do not receive the scrutiny of a quality assurance review. Therefore, the OIG will review brokered claims for errors and report those errors in the inspection reports for the VARO with jurisdiction of those claims.

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<sup>&</sup>lt;sup>3</sup>Audit of Veterans Benefits Administration Compensation and Rating Accuracy and Consistency Reviews (Report No. 08-02073-96, March 12, 2009.)

#### **VARO Profile**

**Organization.** The Wilmington VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Delaware. This is accomplished through the administration of Compensation and Pension Benefits (C&P), Vocational Rehabilitation and Employment (VR&E) Assistance, Burial Benefits, and Outreach activities. The Wilmington VARO does not have any out-based VA offices.

**Resources.** As of March 2009, the Wilmington VARO had a staffing level of 28 Full Time Employees (FTE). Of the 28 FTE, 25 (89 percent) were assigned to the VSC.

**Workload.** As of March 2009, the VARO had 732 pending C&P claims that took an average of 100.3 days to complete, which is approximately 70 days better than the national target of 170 days. Accuracy for C&P rating-related issues, as reported by VBA's STAR, was 82.4 percent, below the national standard of 90 percent. Accuracy for C&P authorization-related issues, as reported by VBA's STAR, was 97.5 percent, above the national standard of 95 percent. As reported by VBA's STAR, accuracy for fiduciary-related activities was 72.2 percent, below the national standard of 90 percent.

#### **Scope of the Inspection**

**Scope.** We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with VBA policies as they related to benefits delivery and non-medical services provided to veterans.

To perform the inspection, we interviewed managers and employees, reviewed veterans' claims folders, and inspected work areas. The disability claims processing review covered VARO operations from January 1, 2009, through March 31, 2009. STAR reviews covered cases reported as errors by STAR staff from January 1, 2009, through March 31, 2009. IRIS and congressional inquiries reviews covered inquiries completed at the VARO from January 1, 2009, through March 31, 2009. Fiduciary activities review covered cases completed from April 1, 2009, through May 19, 2009. The reviews were done in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections*.

#### Appendix A

The inspection covered 15 operational activities in the 5 protocol areas of claims processing, data integrity, management controls, information security, and public contact, as detailed in Table 3 that follows:

**Table 3. Protocols With Activities Reviewed** 

Inspection Protocols				
Claims Processing	Data Integrity	Management Controls	Information Security	Public Contact
15 Activities Reviewed				
Haas Claims	Date of Claim	Systematic Analysis of Operations (SAO)	Mail Handling Procedures	Inquiry Routing and Information System (IRIS)
Post-traumatic Stress Disorder (PTSD) Claims	Control of Veterans Records System (COVERS)	Systematic Technical Accuracy Review (STAR) Compliance	Destruction of Documents	Congressional Inquiries
Traumatic Brain Injury (TBI) Claims		Employee Rotation in Claims Process Improvement (CPI) Model		Fiduciary
Diabetes Claims		Date Stamp Accountability		

# Department of Veterans Affairs

#### **MEMORANDUM**

Date: 8/14/2009

From: Director, VA Regional Office Wilmington

**Subject:** OIG Benefits Inspection of the VA Regional Office

Wilmington, DE

To: Assistant Inspector General for Audit (52)

1. Attached is the Wilmington Regional Office response to the OIG Draft Report: Inspection of the VA Regional Office Wilmington.

2. Questions may be referred to Paul Comstock, Veterans Service Center Manager at (302) 993-7201.

(original signed by:)
THOMAS M. LASTOWKA
Director

Attachment

The following VARO Director's comments are submitted in response to the recommendations in the Office of Inspector General's Report: Inspection of VARO Wilmington, DE during the week of May 26–29, 2009.

#### **A–Disability Claims Processing Findings:**

- 1. Haas Claim (1): Claim improperly identified as Haas claim with EP 335. Concur.
- 2. PTSD Claims (4): Concur.
  - (a) Inappropriate evaluation: This case was not processed by Wilmington RO.
  - (b) Competency issue for 100% vet: This case was not processed by Wilmington RO.
  - (c) Service connection incorrectly established for depression:We do agree that based on no current diagnosis of depression on VA Exam, service connection for depression was not in order.
  - (d) VARO Staff prematurely denied service connection for PTSD based on lack of a verifiable stressful event: This case was not processed by Wilmington RO.
- 3. Diabetes Claim (1): Failure to enter earlier claim date on subsequent rating actions. Concur.

Recommendation 1. The IG recommends the Wilmington VA Regional Office Director ensure refresher training is scheduled and emphasizes the correct procedures for processing Haas, post-traumatic stress disorder, and diabetes claims for Veteran Service Center personnel.

#### Wilmington Response to Recommendation 1:

We concur with the recommendation. Remedial training was given in June 2009 to VSR's to address the correct procedure for processing Haas, PTSD and Diabetes claims.

## **B–Information Security Findings:**

- 1. Storage area for document shredding had faulty door closing mechanism.
- 2. Shred bins were so full that inspectors could reach in slot to retrieve documents.
- 3. Access to shredders should be strictly controlled and limited to senior management, and Division Record Management Officers.
- 4. PII information at employees' desks that were not redacted.

Concur.

Recommendation 2. The IG recommends the Wilmington VA Regional Office Director develop and implement a mechanism to ensure only authorized staff have access to materials designated for destruction.

#### **Wilmington Response to Recommendation 2:**

We concur with the recommendation. Storage Area Door: Repaired door (May 26, 2009). Shred Bins: Obtained another shred bin to house shred material for vendor pick-up. Another bin distributes the shred material and places it lower in the bin so no one can reach inside. Those items were done by June 2009. Access to shred bins is currently limited to the VSCM, Supervisor VSR, and DRMO only by combination lock. Remedial PII training will be conducted to ensure that PII information is redacted as appropriate. The target date is August 2009.

#### **C-Public Contact Findings:**

Ensure processing of Congressional inquiries with VBA policy. Concur.

Recommendation 3. The IG recommends the Wilmington VA Regional Office Director develop and implement a mechanism to ensure Veteran Service Center processes congressional inquires according to VBA policy.

#### **Wilmington Response to Recommendation 3:**

We concur with the recommendation. Effective immediately, VA Form 119 will be completed for each Congressional telephone call and/or e-mail to include information on the date received, date completed and nature of inquiry. A copy of VA Form 119 as well as all controlled correspondence will be placed in the veteran's claims file.

#### **D–Fiduciary Findings:**

IG recommends the Wilmington VA Regional Office Director provide training to Legal Instrument Examiners and Field Examiners on processing Initial Appointments, Fiduciary Beneficiaries, and Accountings as required by VBA policies and procedures. We concur.

1. 1 Initial Appointment (IA)—No verification of beneficiary's funds on deposit with the fiduciary and no verification of current monthly expenses.

Concur that in this case field examiner should have verified funds on hand; provided fund usage and sent appropriate letter to fiduciary.

- 2. 1 Initial Appointment (IA)—Fiduciary's criminal background not thoroughly assessed prior to certifying the fiduciary to provide direction and supervision of VA benefits. Concur. Fiduciary inadvertently checked off both blocks on VA Form 21-0792. However, field exam report clearly states that the legal custodian advised the field examiner that she had never been convicted of a crime.
- 3. 6 1As—No impact errors on veteran's benefits.

Fiduciary Beneficiary (FB) – 5 cases reviewed; 1 error called.

4. 1 FB – Fiduciary unit not properly monitoring fiduciary's use of beneficiary funds as surplus funds not properly discussed and increases in expenses not justified.

Agree that the field exam report did not discuss the disposition of surplus (\$624) funds and the narrative did not fully document justification for increase in room and board from \$400.00 a month to \$800.00 a month.

Accountings: 2 cases reviewed; 1 error called.

5. 1 Accounting – Fiduciary unit did not document beneficiary's account balance and did not provide interest earned for correct accounting period. Agree with the error called. Fiduciary Unit did not document beneficiary's account balance for the correct period and did not provide interest earned for the correct accounting period.

Recommendation 4. The IG recommends the Wilmington VA Regional Office Director provide training to Legal Instrument Examiners and Field Examiners on processing Initial Appointments, Fiduciary Beneficiaries, and Accountings as required by VBA policies and procedures.

#### Wilmington Response to Recommendation 4:

We concur. On June 2, 2009, and July 14–July 15, 2009, training was provided to Program Support Clerk, Legal Instrument Examiner and Veterans Service Representative in Fiduciary on the importance of date stamping all documents received in the Fiduciary Unit.

#### **E – Data Integrity Finding:**

VSC policy to track the location of veteran's claims folders was not enforced.

Concur in part. A review of the cases called for errors showed that 11 of the 14 errors involved cases that were actually properly COVER'd to their current locations; however, errors were called on these cases because they had not been re-COVER'd on the last

Appendix B

designated COVERS day. Therefore, only 3 (10 percent) of the 30 cases were not properly COVER'd to their current locations.

Recommendation 5. The IG recommends the Wilmington VA Regional Office Director establish a mechanism to ensure Veteran Service Center staff uses Control of Veterans Records Systems as required by established policies.

#### **Wilmington Response to Recommendation 5:**

We concur with the recommendation. We will ensure that COVERS day is strictly enforced. All employees memo designating every Friday as COVERS day was rereleased as of July 2009.

#### Appendix C

# **Inspection Summary**

15 Activities	Criteria		Reasonable Assurance of	
Inspected	G.H.O.I.u	Compliance		
		Yes	No	
<b>Claims Processing</b>				
1. Haas	Determine if Haas claims were properly identified and if service connection was correctly granted or denied. (38 CFR 3.313) (M21-1MR Part IV, subpart ii, Chapter 1, Section H) (Fast Letter 09-07 and 06-26)		X	
2. Post-traumatic Stress Disorder (PTSD)	Determine whether service connection for PTSD was correctly granted or denied. (M21-1MR Part III, Subpart iv, Chapter 4, Section H.28.B)		X	
3. Traumatic Brain Injury (TBI)	Determine whether service connection for TBI and all residual disabilities was correctly granted or denied. (Fast Letters 08-34 and 36, Training Letter 09-01)	X		
4. Diabetes	Determine whether service connection for diabetes related to herbicide exposure (Agent Orange) and all related disabilities were correctly granted or denied. (38 CFR 4.119) (Fast letter 02-33) (M21-1MR Part III, Subpart iv, Chapter 4, Section F)		X	
Data Integrity		•		
5. Date of Claim	Determine if VAROS accurately recorded the correct date of claim in electronic records. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)		X	
6. Control Of	Determine if VAROs complied with the use of COVERS to track claims folders.			
Veterans Records			X	
System (COVERS)				
Management Contr				
7. Systematic	Determine if VAROs performed a formal analysis of their operations through			
Analysis of	completion of SAOs. (M21-4, Chapter 5)	X		
Operations (SAO)				
8. Systematic	Determine if VAROs timely and accurately corrected STAR errors. (M21-4, 3.03)			
Technical		X		
Accuracy Review				
(STAR)	Determine if VAROs accounted for and defeavened data storms (M22.1.1.12 h. (1)			
9. Date Stamp	Determine if VAROs accounted for and safeguarded date stamps. (M23-1 1.12, b. (1), (2), (3), (4)) (VBA Letter 20-09-10 Revised dated 3-19-09)	X		
Accountability 10. Claims Process	Determine if VAROs complied with VBA's CPI Implementation Plan 08-05.			
Improvement (CPI)	Determine if VAROS compiled with VBA'S CIT implementation I fair 00-03.	X		
Information Securit	v	1		
11. Mail Handling	Determine if VAROs complied with mail handling procedures. (M23-1) (M21-4,			
Procedures	Chapter 4) (M21-1MR Part III, Subpart ii, Chapter 1 & 4)	X		
12. Destruction of	Determine if VAROs complied with VBA policy regarding proper destruction of			
Documents	documents. (VBA Letter 20-08-63 dated November 14, 2008)		X	
Public Contact		1		
13. Inquiry Routing	Determine if IRIS responses were accurately and timely processed. (Fast Letter 06-10)			
and Information	,, F	X		
System (IRIS)				
14. Congressional	Determine if congressional inquiries were timely processed. (OFO Letter 201-02-60)		**	
Inquiries	(OFO Letter 201-02-64) (Fast Letter 01-40) (VA Directive 8100)		X	
15. Fiduciary	Determine if the Fiduciary unit was properly overseeing the welfare of beneficiaries to include protecting their assets, assuring their benefit entitlement rights, and selecting and monitoring the best-suited fiduciary. (38 CFR 13.100-13.111) ( M21-1MR, Part XI) (FBS Users Guide) (LIE Program Guide)		X	

#### Appendix D

# **OIG Contact and Staff Acknowledgments**

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