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Comment at bottom of page.

**VAOIG: VA'S ROANOKE REGIONAL OFFICE "FACES CHALLENGES"**

Which is IG-speak that means the Office is in shambles. Roanoke RO failed inspection in 6 of 14 operational areas.

*by Larry Scott, VA Watchdog dot Org*

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Today, we present two more VAOIG reports that bring us little, if any, good news.

One of two reports from the [VA's Office of Inspector General \(VAOIG\)](#) released on January 14, 2010 is listed below:

Inspection of VA Regional Office Roanoke, VA -- Report  
Number 09-01995-63, 1/14/2010 | [Summary](#) | [Report \(PDF\)](#)

Same old, same old!

Management has no clue. The staff is not adequately trained. The same errors are made over and over again.

For an eye-opener, read the full report to see just how badly specific veteran's claims were handled.

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**Report Highlights: Inspection of VA Regional Office, Roanoke, VA**

**Why We Did This Review**

The Benefits Inspection Program conducts inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veterans Service Center (VSC) operations.

### **What We Found**

The Roanoke VARO management team faces challenges in providing benefits and services to veterans. The VARO did not meet requirements for 6 of 14 operational areas reviewed.

The Roanoke VARO challenges include addressing oversight of operational activities, acquiring space to support adequate storage of large filing cabinets containing veterans' claims folders, associating claimant evidence with the veterans' claims folders, and providing training to staff.

The VARO management team also needs to provide additional oversight and training of personnel responsible for processing claims identified as traumatic brain injury (TBI), herbicide exposure, and Haas cases.

Additionally, management needs to improve controls over the safeguarding of veterans' personally identifiable information (PII), handling of claims-related mail, and responding to electronic inquiries.

### **What We Recommend**

We recommend that the VARO coordinate with VA contracted medical staff to ensure medical examiners use the most current examination worksheet when evaluating disabilities associated with TBI. In addition, we recommend the VARO improve oversight to ensure proper safeguards of veterans' PII, improve mail-handling procedures in the Triage team, and improve oversight of electronic responses to veterans. Further, the VARO needs to acquire adequate space to store and safeguard veterans' claims folder.

### **Agency Comments**

The Director of the Roanoke VARO concurred with all recommendations. The management team'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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posted by *Larry Scott*  
Founder and Editor  
VA Watchdog dot Org

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