

September 6, 2018

The Honorable Robert Wilkie
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Wilkie,

I write to urgently express my concern about alleged ongoing misconduct at the Bedford, Massachusetts Edith Nourse Rogers Memorial Veterans Hospital (Bedford VA), and to request an update on the status of the criminal investigation into the alleged misconduct that contributed to the death of a Vietnam veteran and patient, William R. Nutter, Jr., in 2016, and any additional active investigations into the Bedford VA.¹ Last October, I wrote a letter to then-Secretary Shulkin asking that he work to expedite the VA Inspector General's (IG) investigation into the allegations regarding Mr. Nutter and brief my staff on its outcome.² He responded in writing that the ongoing nature of the investigation compelled him to withhold any comment at the time.³ Ten months have passed since then without any substantive update on this matter.

Based on credible reports and the VA's own ratings, it is clear that there are systemic problems in the delivery of care to veterans at the Bedford VA. On September 4, 2018, the *Boston Globe* reported on allegations of inadequate care at the veterans' nursing home on the campus of the Bedford VA, which the VA's own ratings indicate as one of the lowest performing nursing homes in the nation.⁴ The most recent report describes allegations of bed sores and "several instances of neglect including a veteran lying naked in bed covered by a urine- and feces-stained sheet," and "another veteran who struggled to shove food into his mouth with his hands after trying unsuccessfully to use a spoon" while staff were close by.⁵ Furthermore, this news report details an atmosphere in which both patients and staff are fearful of retaliation. One veteran is said to be "afraid if he complains he'll be treated even worse," while a now-terminated employee who would only give her first name "remains suspicious that she was targeted for

¹ Boston Globe, "A nurse's aide plays video games while a veteran dies at Bedford VA hospital," Andrea Estes, October 17, 2017, <http://www.bostonglobe.com/metro/2017/10/17/nurse-aide-plays-video-games-while-vietnam-veteran-dies-bedford-medical-center/1sWg0TU12q0mSoxgsa5eFM/story.html>.

² Office of Senator Elizabeth Warren, "Senator Warren Demands Expedited Criminal Investigation into Tragic Death of Veteran at Bedford VA Medical Center," press release, October 20, 2017, <https://www.warren.senate.gov/newsroom/press-releases/senator-warren-demands-expedited-criminal-investigation-into-tragic-death-of-veteran-at-bedford-va-medical-center>.

³ VA Secretary Shulkin response to Sen. Warren, November 1, 2017 [on file with Sen. Warren's office].

⁴ Boston Globe, "Bed sores, neglect, alleged abuse: inside the Bedford VA nursing home," Andrea Estes and Donovan Slack, September 4, 2018, <https://www.bostonglobe.com/metro/2018/09/03/bed-sores-neglect-alleged-abuse-inside-one-lowest-rated-veterans-nursing-homes-country-bedford/9COivG8mpVathjErrrA9nM/story.html>.

⁵ *Id.*

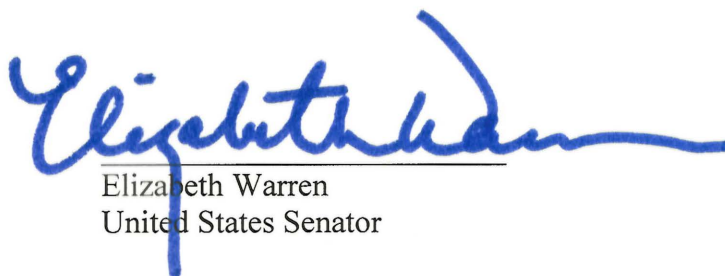
being a whistle-blower” on incidents like a nurse’s aide who carelessly “tossed [an] elderly dementia patient” from his wheelchair onto his bed.⁶ That aide’s alleged misconduct was reportedly regarded by the Bedford VA Director as appropriately resolved because he “quietly resigned.”⁷

The *Globe* report is only the latest in a disturbing pattern of stomach-turning abuse and neglect of veterans at the Bedford VA and raises serious questions about whether the new leadership at this facility is resulting in significantly improved care or is simply producing more of the same. When it comes to our veterans, more of the same old substandard care is unacceptable. I know that most of the staff at the Bedford VA are hardworking and dedicated because I have met with many of them personally, including during a visit with then-Secretary Shulkin last year. But I am growing sick and tired of hearing and reading heart-wrenching story after heart-wrenching story about veterans treated as if their sacrifices for our country do not matter.

It is clear that the Bedford VA is troubled and requires sustained, senior-level oversight and accountability. After this latest report, I lack confidence in the VA’s ability to effectively provide such oversight. On September 5, 2018, I spoke to Veterans Integrated Service Network (VISN) 1 Director Ryan Lilly. In that conversation, Director Lilly committed to providing me with: 1) an update on the status of the investigation into the death of Mr. Nutter and 2) copies of all announced and unannounced inspections and reviews of the Bedford VA by the Long Term Care Institute (LTCI),⁸ without any personally identifiable patient information, since January 1, 2016. I respectfully request that the VA provide this information in a timely manner, and that your staff provide me with a comprehensive briefing on the outcome of the investigation into the death of William R. Nutter, Jr. at the Bedford VA, including any disciplinary action taken against Bedford VA employees, as soon as the investigation is completed.

I look forward to receiving this information as quickly as possible. Thank you for all that you do to honor the service of our nation’s veterans.

Sincerely,



Elizabeth Warren
United States Senator

⁶ *Id.*

⁷ Boston Globe, “Bed sores, neglect, alleged abuse: inside the Bedford VA nursing home,” Andrea Estes and Donovan Slack, September 4, 2018, <https://www.bostonglobe.com/metro/2018/09/03/bed-sores-neglect-alleged-abuse-inside-one-lowest-rated-veterans-nursing-homes-country-bedford/9COivG8mpVathjErrrA9nM/story.html>.

⁸ USA Today, “Secret VA nursing home ratings hide poor quality care from the public,” Donovan Slack and Andrea Estes, June 17, 2018, <https://www.usatoday.com/story/news/politics/2018/06/17/secret-va-nursing-home-ratings-hide-poor-quality-care/674829002/>.