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October 20, 2017

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

RE: Failure of Care at Bedford, MA VA Medical Center

Dear Secretary Shulkin,

I write to express my extreme concern and outrage at the death of a patient at the Bedford, Massachusetts Department of Veterans Affairs (VA) Medical Center and to request, on behalf of the people of Massachusetts, that you expedite the VA Inspector General's (IG) criminal investigation into the circumstances that led to this tragedy and then promptly brief my staff on its outcome.

As you know, according to a recent report in the *Boston Globe*, William R. Nutter, Jr., a patient at the Bedford VA Medical Center, died on July 3, 2016, while under the facility's care. According to public reports and an internal VA investigation,[1] Mr. Nutter, a veteran with two tours of duty in the Vietnam War and 21 years of service in the U.S. Army Reserves, died allegedly in part due to the neglect of a nurse on duty who was playing video games and failed to monitor him. My understanding is that the nurse on duty was initially transferred from her post to a food service position at the Bedford VA, and has since been placed on administrative leave and is pending termination of her employment. Reports further indicate that the VA Inspector General is conducting a criminal investigation in coordination with the Department of Justice and the Federal Bureau of Investigation to examine the structural problems at the Bedford VA that allowed Mr. Nutter, "a very vulnerable patient, in danger of cardiac arrest at any given moment due to an arrhythmia,"[2] to suddenly die.

As you are no doubt aware, the Bedford VA has been the subject of other IG investigations in recent months, including for allegations that employees sold narcotics on hospital grounds and engaged in inappropriate relationships with patients. According to local press reports, a whistleblower who reported this behavior to your office has subsequently faced retaliation from other employees and hospital administration.[3] In part as a result of these complaints, the Bedford VA has had significant turnover in its leadership, and is now on its third

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[1] Andrea Estes, "A nurse's aide plays video games while a veteran dies at Bedford VA hospital," Boston Globe, Oct. 17, 2017, http://www.bostonglobe.com/metro/2017/10/17/nurse-aide-plays-video-games-while-vietnam-veteran-dies-bedford-medical-center/IsWg0TU12q0mSoxgsa5eFM/story.html?event=event12.
[2] *Id.*
[3] Todd Feathers, "VA whistleblower says he's being harassed," Lowell Sun, Feb. 10, 2017, http://www.lowellsun.com/breakingnews/ci_30786839/va-whistleblower-says-hes-being-harassed.

hospital director in less than a year.[4] There are also allegations that the Bedford office of the VA Inspector General has allowed an environment at this VA medical facility "where mistakes are swept under the rug."[5]

It is unacceptable that these incidents continue to mount, with little or no action taken until such stories are made public in press reports. It is the solemn obligation of the VA to proactively address any underlying issues undermining the provision of care to veterans at Massachusetts facilities. Accordingly, I request that you assign an investigatory team from outside the Bedford area to thoroughly review this case. Such a review should consider whether any underlying cultural or structural issues – including deficiencies in personnel oversight, patient management, and health care standards – contributed in any way to the death of Mr. Nutter or put any current patients at risk. Furthermore, if the VA Inspector General's investigation reveals evidence that by their action or inaction, other employees – including senior administrators – contributed in any way to Mr. Nutter's tragic death, then those employees should be immediately fired.

While the majority of our VA employees are hard-working and dedicated to patient care, any failure of care is unacceptable, and VA employees must be held accountable when they cut corners in the delivery of care to our veterans. Patients at the Bedford VA Medical Center are not serial numbers in a file – they are heroes who deserve the highest quality care. It is beyond outrageous that someone in the care of the VA died because an employee was apparently more interested in playing a video game than checking on him, and it strains belief that such a monumental mistake could occur without much broader breakdowns in professionalism and accountability. The family of Mr. Nutter deserves real and complete answers as to why he died and who is responsible, which is why I am anxious to learn the results of the VA Inspector General's investigation.

Please do not hesitate to reach out to Feras Sleiman (Feras_Sleiman@warren.senate.gov) or Sasha Baker (Sasha_Baker@warren.senate.gov) on my staff to update my office on the outcome of this criminal inquiry as soon as it is complete. Thank you for your work on behalf of our veterans in Massachusetts and across the nation.

Sincerely,

Elizabeth Warren
United States Senator

[4] Todd Feathers, "Bedford VA whistleblower: Agency trying to 'scare me away' through retaliation," Lowell Sun, Oct. 17, 2017, http://www.lowellsun.com/local/ci_31381379/bedford-va-whistleblower-agency-trying-scare-me-away.

[5] Todd Feathers, "Behind midnight escape, a botched VA probe," Lowell Sun, Aug. 27, 2017, http://www.lowellsun.com/todaysheadlines/ci_31252826/behind-midnight-escape-botched-va-probe.