

Congress of the United States
Washington, DC 20510

June 16, 2020

Michael J. Missal
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Mr. Missal:

We write to request that the Department of Veterans Affairs Office of Inspector General (VA OIG) investigate the death of a veteran, non-patient resident of a building leased by a private company and located on the campus of the Bedford Department of Veterans Affairs Medical Center (VAMC) in Bedford, Massachusetts.¹

Our understanding based on public reports and a June 15, 2020, briefing for Congressional staff by the Bedford VA leadership is that a 62-year-old veteran, non-patient resident of an independent-living facility on property (Building #5) leased by Caritas Communities from the Bedford VAMC was found dead on June 12, 2020, by another resident in the facility's stairwell, which is accessed only by residents. The deceased veteran had been reported missing by Caritas, "a nonprofit homelessness prevention organization,"² since May 13 and was found in the same clothing in which he was last seen, which was five days earlier.³ We understand that, while the building has a Caritas property manager on site and some veteran residents receive services from the Bedford VAMC, the residents of this building are private citizens who have complete freedom of movement and are not required to account for their whereabouts to anyone.

In a statement on June 13, 2020, Caritas Communities asserted, "The stairwell where the deceased man was found was outside the lease premises of Caritas Communities, is alarmed and solely controlled by the VA."⁴ We understand that the Bedford VAMC performs an annual inspection of the Caritas-leased building to ensure that its conditions are consistent with the terms of its lease agreement, and that VA police may access the stairwell in emergencies.

¹ WCVB, "Body found in stairwell on VA campus 5 weeks after man went missing," June 13, 2020, <https://www.wcvb.com/article/body-found-in-stairwell-five-weeks-after-man-went-missing/32854209#>.

² The Bedford Citizen, "Caritas Communities' Statement on the Death of a Resident in its Bedford Veterans Quarters," Ann Meneely, June 13, 2020, <https://www.thebedfordcitizen.org/2020/06/caritas-communities-statement-on-the-death-of-a-resident-in-its-bedford-veterans-quarters/>.

³ CNN, "Veteran missing for a month found dead in stairwell at VA hospital," Taylor Romine, June 16, 2020, <https://www.cnn.com/2020/06/16/us/missing-veteran-found-dead-hospital/index.html>.

⁴ The Bedford Citizen, "Caritas Communities' Statement on the Death of a Resident in its Bedford Veterans Quarters," Ann Meneely, June 13, 2020, <https://www.thebedfordcitizen.org/2020/06/caritas-communities-statement-on-the-death-of-a-resident-in-its-bedford-veterans-quarters/>.

However, we have also been informed that this stairwell only serves Caritas residents, is the only emergency exit door, and its cleanliness is the responsibility of Caritas. We are concerned that a lack of clear responsibility for oversight and maintenance of this staircase, which is located in a building on VA property, could have had an impact on the case in question. Furthermore, the unwillingness of either party to claim responsibility for the property in question raises concerns that there could be other cases where facilities that are located on VA property, but not run by the VA, also lack clearly delineated maintenance and oversight responsibilities in leases and contracts, allowing the possibility that another similar instance could occur in the future.

We were informed in our June 15 briefing with Bedford VA leadership that this matter is under investigation by the Massachusetts State Police, which is apparently the standard procedure for an unattended death of a non-patient on VA property. Currently, we reserve judgment regarding the parties responsible for this veteran's death. At the same time, it is undisputed that a veteran died on VA property and that his family deserves a thorough, independent investigation by relevant authorities. Accordingly, it is consistent with the mission of the VA Inspector General⁵ to review the circumstances that led to this veteran's death and to determine accountability for this tragedy, including an examination of the terms of the lease agreement between the Bedford VAMC and Caritas Communities as well as recommendations for how such an incident can be avoided in the future. Therefore, we respectfully request that you initiate an investigation into the recent death of a veteran on the campus of the Bedford VAMC. We look forward to your prompt reply.

Sincerely,

/s/
Elizabeth Warren
United States Senator

/s/
Edward J. Markey
United States Senator

/s/
Katherine Clark
Member of Congress

/s/
Seth Moulton
Member of Congress

/s/
Lori Trahan
Member of Congress

⁵ U.S. Department of Veterans Affairs, Office of Inspector General, "Mission, Vision, Values," <https://www.va.gov/oig/pubs/VA-OIG-Mission-Vision-Values.pdf>.