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October 3, 2018

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

Dear Mr. Missal:

I write to repeat my request for an update on the status of the Department of Veterans Affairs (VA) Inspector General's criminal investigation into the death of William R. Nutter, Jr. at the Bedford, Massachusetts Edith Nourse Rogers Memorial Veterans Hospital (Bedford VA) in July 2016.[1] After my initial request for information in October 2017, the VA indicated that the investigation into this tragedy was still ongoing.[2] But, almost a year has passed after my initial request, and over two years have passed since Mr. Nutter's death. Accordingly, I believe that the Inspector General should provide a clear, substantive update on the status of this investigation, including who was held accountable and how a similar incident can be prevented in the future.

Bill Nutter, a veteran with two tours of duty in the Vietnam War and 21 years of service in the U.S. Army Reserves, died on July 3, 2016 allegedly in part due to the neglect of a nurse on duty who was playing video games and failed to monitor him. On October 20, 2017, I wrote to then-Secretary Shulkin requesting that he encourage the VA Inspector General to expedite its investigation in the circumstances that led to Mr. Nutter's death and promptly brief my staff on its outcome. On November 1, 2017, then-Secretary Shulkin replied to me that "further comment is not appropriate at this time" in order "to protect the integrity of the active investigation."[3] On September 6, 2018, upon my verbal request for an update on this investigation, Director of the VA's New England network of VA medical centers (VISN 1) Ryan Lilly conveyed to me: "Per the OIG Resident Agent in Charge, the case is being coordinated with the US Attorney's Office and remains an open investigation at this time."[4]

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[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/IsWg0TU12q0mSoxgsa5eFM/story.html; Lowell Sun, "Warren calls for VA probe on Bedford patient's death," Alana Melanson, October 20, 2017, http://www.lowellsun.com/breakingnews/ci_31391348/warren-calls-va-probe-bedford-patients-death; 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.

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

[3] *Id.*

[4] VISN 1 Director Ryan Lilly response to Sen. Warren, September 6, 2018 [on file with Sen. Warren's office].

Since Bill Nutter's death, more than two years have passed without the release of any public findings or conclusions by the Inspector General. While I understand that the Inspector General requires time to conduct thorough and independent investigations, the family of Mr. Nutter deserves a full and transparent explanation of why he died, who was disciplined, and what steps have been or need to be taken to prevent any tragedy of this kind from occurring again.

The VA Inspector General aims to be "an independent and fair voice for veterans and their families that makes meaningful improvements to VA programs and services, while being responsive to the concerns of veterans service organizations, Congress, VA employees, and the public."[5] In that spirit, I believe it is long past time for the Inspector General to provide a meaningful update on the progress of its investigation and to publicly release its conclusions. I hope that the Inspector General's findings and conclusions, when released, will help ensure that there are no more veterans like Bill Nutter who senselessly die under the care of the Bedford VA or any other VA medical facility.

Thank you for your work on this important matter.

Sincerely,

Elizabeth Warren
United States Senator

[5] U.S. Department of Veterans Affairs, Office of the Inspector General, Mission, Vision, and Values, https://www.va.gov/oig/pubs/VA-OIG-Mission-Vision-Values.pdf.