



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Special Reviews*

VETERANS HEALTH ADMINISTRATION; OFFICE OF  
OPERATIONS SECURITY AND PREPAREDNESS;  
OFFICE OF MANAGEMENT

# Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus



## MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

*In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.*

**Report suspected wrongdoing in VA programs and operations  
to the VA OIG Hotline:**

[www.va.gov/oig/hotline](http://www.va.gov/oig/hotline)

**1-800-488-8244**



## Executive Summary

On June 12, 2020, a resident of the Bedford Veterans Quarters (BVQ), a privately operated, independent-living facility for veterans on the campus of VA's Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts (the medical center or facility), encountered a significantly decayed body in the emergency exit stairwell of the building in which the BVQ is located. The body was later identified as that of a BVQ resident who had been reported missing on May 13, 2020, and whose room was just down the hall from the entrance to the stairwell. The veteran was wearing the same clothes that he had been reported wearing on May 8, 2020, the last time he was seen prior to his disappearance: a Boston Red Sox jersey, jeans, and a baseball cap.<sup>1</sup>

The man found in the Building 5 stairwell was Timothy White, a 62-year-old US Army veteran who had recently struggled with homelessness.<sup>2</sup> In January 2020, Mr. White began living at the BVQ, a single-room-occupancy program operated by Caritas Communities Inc. (Caritas) in space leased through VA's enhanced-use lease program.<sup>3</sup> At the time of his disappearance, as reported to the Bedford Police Department by Caritas's house manager, Mr. White had no cellphone, no car on campus, and "had never been known to leave the [BVQ] without explanation."<sup>4</sup> Yet tragically those who were informed about his disappearance—including BVQ management (Caritas), Bedford police, and VA police and staff—never searched the emergency exit stairwell in which he was later found dead at any time during the month after he was reported missing.<sup>5</sup>

---

<sup>1</sup> Middlesex County District Attorney's Office, *Findings of Middlesex District Attorney Marian Ryan Regarding the Circumstances Surrounding the Death of Timothy White at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, MA*, December 4, 2020, [https://www.middlesexda.com/sites/g/files/vyhlif4691/f/news/findings\\_of\\_middlesex\\_da\\_marian\\_ryan\\_regarding\\_the\\_death\\_of\\_timothy\\_white\\_-\\_for\\_release.pdf](https://www.middlesexda.com/sites/g/files/vyhlif4691/f/news/findings_of_middlesex_da_marian_ryan_regarding_the_death_of_timothy_white_-_for_release.pdf) (district attorney's report) at 1.

<sup>2</sup> Andrea Estes, "A Veteran Died 20 Yards from his Room on the Bedford VA Campus," Boston Globe, June 18, 2020; district attorney's report. Consistent with the Privacy Act and OIG policy, the OIG removes identifiers in its reports for individuals when necessary to protect the privacy and identity of involved parties and witnesses where those privacy interests outweigh the public interest in disclosure. Although the OIG generally does not find that the public interest outweighs a veteran patient's privacy interests, the OIG made a different decision with respect to Mr. White in this report because he was previously publicly identified in the district attorney's report, as well as in media reports regarding his death. Inclusion of his name allows the OIG to clearly and respectfully recognize Mr. White.

<sup>3</sup> VA's enhanced-use lease program permits VA to repurpose underutilized real estate by leasing it to private developers to convert into housing for veterans who are experiencing homelessness or are otherwise at risk of homelessness. VA Office of Asset Enterprise Management, "Enhanced-Use Lease Program Fact Sheet," March 27, 2019, <https://www.va.gov/assetmanagement/docs/overviewEulProgram.pdf>.

<sup>4</sup> District attorney's report, at 3.

<sup>5</sup> Issues related to the response of Caritas or the Bedford Police Department with respect to Mr. White's disappearance are outside the scope of this report. (For more information on Caritas and Bedford police, see the district attorney's report.)

Mr. White's death generated significant media attention.<sup>6</sup> Within days, several members of Congress requested that VA's Office of Inspector General (OIG) and the VA Secretary investigate the circumstances surrounding Mr. White's death, including identifying deficiencies in VA's practices at the facility and developing recommendations aimed at preventing such an incident from reoccurring.<sup>7</sup> The OIG promptly opened an administrative investigation to assess VA's role in the tragedy but paused aspects of its review until after the local district attorney's office closed its criminal investigation in December 2020.<sup>8</sup> The OIG has now completed its administrative investigation and presents the findings in this report.

There is specific VA guidance for locating missing patients on medical center campuses. Veterans Health Administration (VHA) Directive 2010-052 requires VA police to conduct specific searches, including of adjacent stairwells, and follow other detailed procedures designed to ensure a thorough and prompt response to a suspected disappearance of an at-risk patient.<sup>9</sup> In this case, however, Mr. White was not considered to be a VA *patient* under the directive, although he was actively enrolled in the VA healthcare system. Instead, he was considered a *resident* of the medical center campus because he lived in a privately operated housing facility leased by VA for use by veterans. The OIG found that VA police would have been required to search the emergency stairwell if Mr. White had been considered an at-risk missing patient under VHA's directive, and if VA police had followed the VHA directive, he likely would have been located by VA police shortly after he was reported missing.

---

<sup>6</sup> See, e.g., "Man Missing for a Month Found Dead Inside Bedford VA Hospital," *CBS Boston*, June 12, 2020, <https://boston.cbslocal.com/2020/06/12/missing-man-found-dead-bedford-va-hospital>; Alexi Cohan, "Man Found Dead in Stairwell at Bedford VA Hospital Campus a Month After He Went Missing," *Boston Herald*, June 13, 2020; Taylor Romine, "Veteran Missing for a Month Found Dead in Stairwell at VA Hospital," *CNN*, June 16, 2020; Estes, "A Veteran Died."

<sup>7</sup> Letter from Senators Elizabeth Warren and Edward Markey and Representatives Katherine Clark, Seth Moulton, and Lori Trahan to Inspector General Michael Missal, June 16, 2020; letter from Representative Joseph P. Kennedy III to VA Secretary Robert Wilkie, June 19, 2020.

<sup>8</sup> The OIG held off on conducting its administrative investigative interviews during the Middlesex County District Attorney's Office criminal investigation of Mr. White's death, which was led by the Massachusetts State Police with assistance from special agents in the OIG's Office of Investigations. On December 4, 2020, the district attorney's office issued its report, and OIG investigators resumed interviews as part of the administrative investigation. Middlesex County District Attorney's Office, *Findings Released Regarding Investigation into the Circumstances Surrounding the Death of Timothy White at the Bedford Veterans Hospital*, December 4, 2020, <https://www.middlesexda.com/press-releases/news/findings-released-regarding-investigation-circumstances-surrounding-death>. The report noted that the medical examiner was unable to determine a cause of death due to the delay in discovering the body and its resulting state; the district attorney concluded that "no assessment of whether his death was the product of wanton or reckless conduct can be made by this Office." As of August 20, 2021, no charges had been publicly filed by the district attorney's office.

<sup>9</sup> VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

However, whether or not Mr. White was a patient, other governing federal law and agency policies require VA police to patrol all VA property and to protect persons on that property.<sup>10</sup> Yet the OIG found that, just months before Mr. White's disappearance, the VA police chief had improperly instructed his officers to stop patrolling Building 5. He claimed that it was at the request of Caritas managers, but there is conflicting testimony concerning this assertion. In any case, the police chief's decision violated the governing law and VA policy because substantial portions of Building 5 remained under VA's jurisdiction, including the basement, the emergency exit stairwells, VA first-floor offices, and a VA-funded temporary bed program for veterans experiencing homelessness. In addition, the chief's order contradicted the express terms of VA's lease with Caritas, which required VA to provide for "police patrol and protection . . . and emergency services to the Property at its sole cost and expense."

Finally, the OIG found that there was widespread confusion regarding the physical area covered by the Caritas lease and VA's related obligations. As a result of VA personnel's mistaken belief that Caritas was responsible for Building 5's emergency exit stairwells, medical center staff never cleaned the stairwell where Mr. White was found dead during the month after he was reported missing (or at any time during the maintenance chief's tenure that began in 2014). This misunderstanding lingered due to inadequate guidance and oversight by the Office of Asset Enterprise Management (OAEM), VA's enhanced-use lease program office, as well as poor communication and coordination between OAEM, the VA local lease site monitor, and medical facility managers. At a basic level, VA failed to ensure that the medical center had a clear understanding of what space belonged to VA and what its maintenance responsibilities were under the lease—even with respect to spaces that affected tenant safety, such as the emergency exit stairwells.

The OIG made seven recommendations relating to improvements in policies and procedures in VHA, OAEM, and the Office of Security and Law Enforcement. Because the VA police chief resigned in February 2021, the OIG cannot make any recommendation with respect to his conduct in this matter. Nothing in this report precludes VA from taking any other administrative action it may deem appropriate as to current VA employees.

In response to this report, the acting under secretary for health, the executive director of the Office of Security and Law Enforcement, and the executive director of OAEM provided written comments in which they concurred with the OIG's findings and recommendations. They provided action plans to implement the recommendations, which the OIG will monitor. The OIG also received comments from the Veterans Integrated Service Network 1 (VISN 1) director that oversees the medical center, although he was not requested or obligated to do so because none of

---

<sup>10</sup> 38 U.S.C. § 901; VA Directive 0730, *Security and Law Enforcement*, December 12, 2012, at 1; VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000, at 1.

the recommendations were directed to him. All VA responses and written comments are published in their entirety as appendix B, followed by the OIG's reply to the VISN 1 director's remarks.

A handwritten signature in black ink, appearing to read 'Katherine Smith', written in a cursive style.

KATHERINE SMITH  
Assistant Inspector General  
for Special Reviews

## Contents

Executive Summary .....	i
Abbreviations .....	vi
Introduction.....	1
Findings and Analysis.....	6
Finding 1: VA Police Failed to Locate Mr. White in Part Because VHA Policy Only Requires Searches for Missing Patients but Not Missing Residents.....	6
Finding 2: VA Police Also Failed to Locate Mr. White Due to the Police Chief’s Improper Decision to Cease Patrols of the Building in which He Was Found .....	11
Finding 3: Inadequate OAEM Oversight and Guidance Regarding the Caritas Lease Contributed to Confusion over VA’s Responsibility for Cleaning Building 5’s Emergency Exit Stairwells.....	15
Conclusion .....	21
Appendix A: Scope and Methodology.....	22
Appendix B: Management Comments and OIG Response.....	23
OIG Contact and Staff Acknowledgments .....	36
Report Distribution .....	37

## Abbreviations

BVQ	Bedford Veterans Quarters
COO	Chief Operating Officer
EMS	Environmental Management Service
EUL	Enhanced-Use Lease
LSM	Local Site Manager
OAEM	Office of Asset Enterprise Management
OIG	Office of Inspector General
OSLE	Office of Security and Law Enforcement
SOP	Standard Operating Procedure
VHA	Veterans Health Administration
VISN 1	Veterans Integrated Service Network 1



## Introduction

This report examines VA's role in the failure to locate a missing veteran, Mr. Timothy White, whose remains were found in a stairwell at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts (the medical center or facility). It identifies specific gaps in policies and practices used by the Veterans Health Administration (VHA), the Office of Security and Law Enforcement (OSLE), and the Office of Asset Enterprise Management (OAEM). Mr. White resided at the Bedford Veterans Quarters (BVQ), an independent-living facility for veterans experiencing homelessness, which was located on the medical center campus. Mr. White had been reported missing on May 13, 2020. On June 12, 2020, he was found dead in the emergency exit stairwell of the BVQ building by another resident. The BVQ is operated by a private nonprofit, Caritas Communities Inc. (Caritas), in space that Caritas leases from VA (the Caritas lease) pursuant to VA's enhanced-use lease (EUL) program.<sup>11</sup>

News outlets began reporting on the incident shortly after Mr. White's body was found.<sup>12</sup> On June 16, 2020, VA's Office of the Inspector General (OIG) received a letter from Senators Elizabeth Warren and Edward Markey, and Representatives Katherine Clark, Seth Moulton, and Lori Trahan requesting an investigation.<sup>13</sup> Specifically, the OIG was asked 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 [medical center] and Caritas Communities as well as recommendations for how such an incident can be avoided in the future."<sup>14</sup> Representative Joseph P. Kennedy III also sent a letter to the VA Secretary on June 19,

---

<sup>11</sup> Caritas leases the space through its subsidiary, Bedford Veterans Quarters, Inc. (BVQ, Inc.). Although primarily a landlord, Caritas also provides "case management," which it describes as including "medical, mental health and employment referrals, food assistance and activity groups." Under the terms of the lease with VA, Caritas is required to provide "case management services," and, in fact, during the OIG's investigation, was subject to a formal cure notice from VA regarding its failure to provide evidence that case management services were being provided to the BVQ residents.

<sup>12</sup> See, e.g., "Man Missing for a Month Found Dead Inside Bedford VA Hospital," *CBS Boston*, June 12, 2020, <https://boston.cbslocal.com/2020/06/12/missing-man-found-dead-bedford-va-hospital>; Alexi Cohan, "Man Found Dead in Stairwell at Bedford VA Hospital Campus a Month After He Went Missing," *Boston Herald*, June 13, 2020; Taylor Romine, "Veteran Missing for a Month Found Dead in Stairwell at VA Hospital," *CNN*, June 16, 2020.

<sup>13</sup> Letter from Senators Elizabeth Warren and Edward Markey and Representatives Katherine Clark, Seth Moulton, and Lori Trahan to Inspector General Michael Missal, June 16, 2020.

<sup>14</sup> The June 16, 2020, letter also raised questions as to whether "there could be other cases where facilities that are located on VA property, but not run by VA, also lack clearly delineated maintenance and oversight responsibilities." Letter from Sen. Elizabeth Warren et al. to Inspector General Michael Missal, June 16, 2020. OAEM's executive director testified that his staff reviewed property descriptions in other EULs after the veteran was found and did not identify any other leases of a partial building. He indicated that his staff did not document the process or results of the review. Accordingly, the OIG recommends, as discussed below in finding 3, that OAEM conduct a formal, documented review of all active EULs to determine whether any involve portions of buildings also occupied by VA, and, if so, whether they are clear regarding maintenance and security obligations.

2020, requesting an “independent investigation to identify specific gaps in current practices at the [facility].”<sup>15</sup>

In response to these requests, the OIG opened this investigation on or about July 13, 2020, but was asked to pause aspects of its investigation due to an ongoing criminal investigation by the Middlesex County District Attorney’s Office. On December 4, 2020, the district attorney issued her report.<sup>16</sup> According to the report, the state medical examiner’s office conducted an autopsy on June 13, 2020, and did not find evidence of trauma or suspect any foul play.<sup>17</sup> The report noted that the medical examiner was unable to determine a cause of death due to the delay in discovering Mr. White’s body and its resulting state; the district attorney concluded that “no assessment of whether his death was the product of wanton or reckless conduct can be made by this Office.”<sup>18</sup> The district attorney’s report also indicated that the examiner could not opine as to the date of Mr. White’s death but indicated it was plausible that his body had been there for 30 days. The district attorney’s report did not announce any criminal charges regarding Mr. White’s death, and, as of August 20, 2021, no charges had been publicly filed.

Once the district attorney’s office completed its report, the OIG was able to proceed with interviews and complete its own administrative investigation of the circumstances surrounding Mr. White’s death. (For more information on the OIG administrative investigation’s scope and methodology, see appendix A.)

## Events Following Mr. White’s Disappearance

The BVQ house manager was the individual who reported that Mr. White was missing on May 13, 2020. The house manager first emailed the Caritas chief operating officer (Caritas COO) and indicated Mr. White had not been seen in five days and that there had “been several checks in his room and he’s not on the property.” That same day, the Caritas COO forwarded this message to the Bedford VA’s chief of social work, stating, “FYI, we are tracking a tenant. Will keep you abreast.” The chief of social work responded that Caritas “should put in a missing

---

<sup>15</sup> Letter from Representative Joseph P. Kennedy III to VA Secretary Robert Wilkie, June 19, 2020.

<sup>16</sup> Middlesex County District Attorney’s Office, *Findings Released Regarding Investigation into the Circumstances Surrounding the Death of Timothy White at the Bedford Veterans Hospital*, December 4, 2020, <https://www.middlesexda.com/press-releases/news/findings-released-regarding-investigation-circumstances-surrounding-death>.

<sup>17</sup> Middlesex County District Attorney’s Office, *Findings of Middlesex District Attorney Marian Ryan Regarding the Circumstances Surrounding the Death of Timothy White at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, MA*, December 4, 2020, [https://www.middlesexda.com/sites/g/files/vyhlif4691/f/news/findings\\_of\\_middlesex\\_da\\_marian\\_ryan\\_regarding\\_the\\_death\\_of\\_timothy\\_white\\_-\\_for\\_release.pdf](https://www.middlesexda.com/sites/g/files/vyhlif4691/f/news/findings_of_middlesex_da_marian_ryan_regarding_the_death_of_timothy_white_-_for_release.pdf) (district attorney’s report), at 2.

<sup>18</sup> District attorney’s report, at 8.

person report as [Mr. White] has not been seen in over 72 hours.” The Caritas COO subsequently instructed the house manager to contact the Bedford Police Department to file a police report.

According to multiple sources, including the district attorney’s report, the following describes the sequence of subsequent events on the day Mr. White was reported missing. The house manager (consistent with the Caritas COO instruction) first contacted the Bedford police.<sup>19</sup> An officer came to Building 5, met with the house manager outside of the building, and formally took the missing person report. The officer noted in his police report that Mr. White was last seen on May 8, 2020, “wearing white sneakers, blue jeans, a Red Sox jersey, and a dark colored baseball cap.” The report noted also that Mr. White did not have a cellphone or a vehicle on campus and “had never been known to leave [the BVQ] without explanation.” The police officer did not enter the building or perform a search due in part to COVID-19 restrictions, according to the district attorney’s report, which also indicated that the Caritas manager had reported to the officer that she had checked Mr. White’s room and could not locate him. The Bedford police officer then went to the VA police station on the medical center campus and spoke with a VA police officer to alert him of Mr. White’s disappearance. The Bedford police officer entered Mr. White into national law enforcement databases as a missing person. The following morning, the BVQ house manager also stopped by the VA police department office to alert them of the missing person report that Caritas had filed, though the lieutenant with whom she spoke indicated that VA police were already aware of the report.

After being notified of Mr. White’s disappearance, the VA police department’s response was extremely limited. A VA police officer who was on duty the night Mr. White was reported missing indicated that because Caritas had not directly “called VA Police . . . a response and report [were] not initiated.” The VA police officer sent an email to all VA police about the missing veteran and posted his picture on a bulletin board in the VA police dispatch area. Additionally, the officer “conducted an unreported foot patrol through the tree-line [in an area of the campus behind Building 5] with [his] flashlight.”<sup>20</sup> However, VA police did not search the inside of Building 5.

In addition, on May 14, 2020, according to the district attorney’s report, the Bedford police chief contacted the VA police chief and left him a voicemail requesting that VA police dogs be used to search the property. The VA police chief did not respond to the message until May 27, 2020, when he stated in an email to the Bedford police chief that he had just received his “phone back from IT [because the] phone was dropped” and discovered that he had missed a call from him.

---

<sup>19</sup> The Bedford Police Department was contacted first despite the requirement in the lease that states that initial calls for assistance should be made to VA police.

<sup>20</sup> In the days following the missing person report, this VA police officer occasionally returned to this area in search of the missing veteran.

The VA police chief thanked the Bedford police chief for “reaching out to coordinate the effort in locating this individual.” The VA police chief did not mention anything about the request for K-9 support, and the VA police K-9 unit was never activated to attempt to locate Mr. White—either prior or subsequent to this request.<sup>21</sup>

On June 12, 2020, nearly a month after Mr. White was initially reported missing, a BVQ resident found his body in Building 5’s emergency exit stairwell. He was wearing the same clothes that he was reported to have been wearing at the time of his disappearance. The entrance to the stairwell was accessible from inside the BVQ and was located a short distance from the room occupied by Mr. White.

### **The Caritas Lease and Building 5**

VA partially leased Building 5 at the medical center in 2004 to Vietnam Veterans Workshop, Inc. under an EUL agreement for a term of 55 years to operate the BVQ.<sup>22</sup> The EUL was later amended in 2006 with an assignment to BVQ Inc., which as noted previously is controlled by Caritas.

The Caritas lease states that the tenant will have “exclusive use of approximately 23,686 square feet of floor space in Building Number Five (5).” The lease highlights that the space will consist of areas on both the first floor and second floor of Building 5 and that it also “includes all the space north of the centerline of the main lobby, and . . . the entire center wing on each floor.” As shown in figure 1 below, the first floor of Building 5 is split into two sections, and one side is VA office space, and the other is area leased by Caritas.

---

<sup>21</sup> The VA police chief’s interview on February 3, 2021, was cut short due to health issues before OIG investigators were able to ask him why he did not direct the K-9 unit to search the building as requested. The police chief subsequently resigned effective February 12, 2021, citing health concerns and declined to complete the interview.

<sup>22</sup> EULs allow VA to lease underutilized buildings and/or land to third parties to provide housing to veterans experiencing homelessness. EULs have lengthy terms ranging from 19 to 75 years.

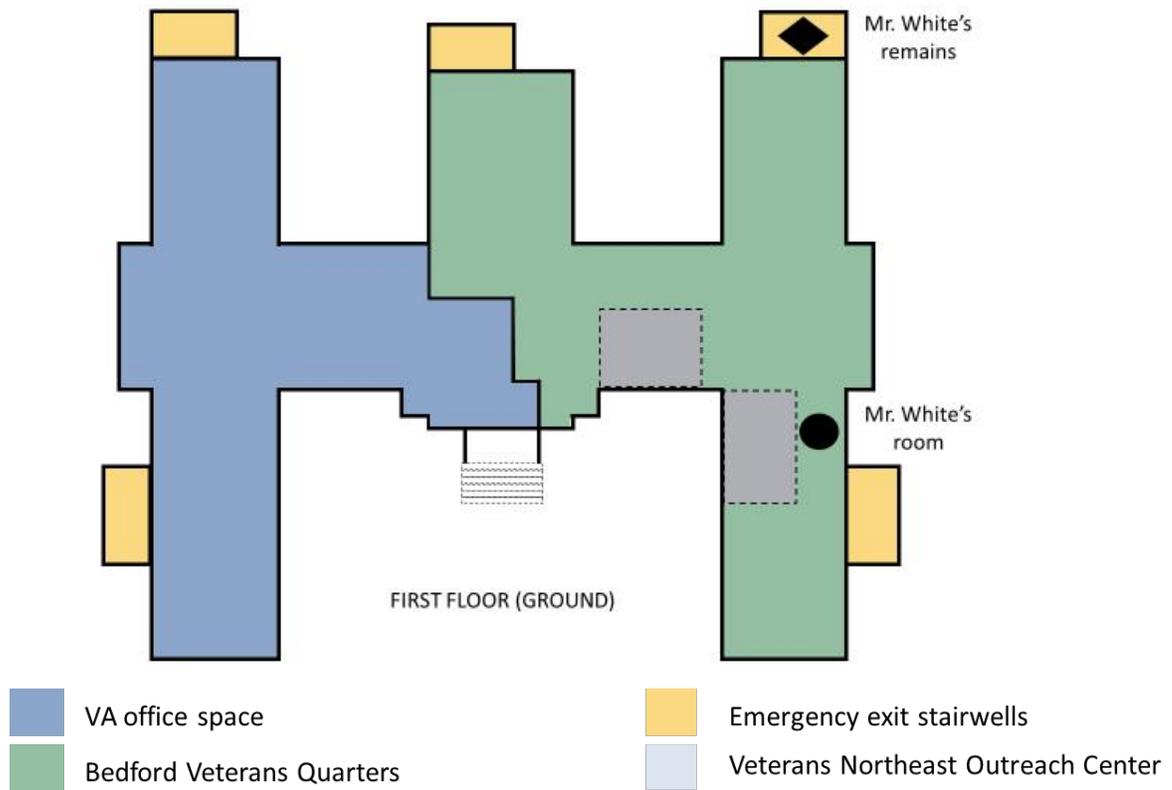


Figure 1. Allocation of space on the first floor of Building 5.

Source: OIG Analysis

Caritas subleases a portion of its first-floor leased space to the Veterans Northeast Outreach Center, as indicated by the gray shading in figure 1, which contracts with VA to provide temporary and transitional living quarters for veterans who are experiencing homelessness. The emergency exit stairwells are outside of the area leased to Caritas and remained VA property. The emergency exit stairwell in which Mr. White was found is accessible from the first and second floors of the BVQ.<sup>23</sup>

<sup>23</sup> There is also a basement in Building 5, which primarily consists of mechanical rooms. It is connected to an underground tunnel system, and it is not part of the area leased to Caritas.

## Findings and Analysis

### **Finding 1: VA Police Failed to Locate Mr. White in Part Because VHA Policy Only Requires Searches for Missing Patients but Not Missing Residents**

The limited response of the Bedford VA police to the report of Mr. White's disappearance, including their decision not to search the inside of Building 5, was heavily influenced by their view that he was considered to be a resident and not a patient of the medical center. VHA Directive 2010-52, titled "Management of Wandering and Missing Patients," instructs clinical staff and VA police to conduct searches when a patient is reported missing. In contrast, there is no specific national directive or operating procedure that requires VA police to take similar steps when individuals not considered patients are reported missing. The OIG found that the absence of any such guidance contributed to inaction by VA police.

#### **VA Police Would Have Been Required to Search the Emergency Stairwell if Mr. White Had Been Considered a Missing Patient under VHA Directive**

VHA and local policies demand thorough responses from medical center staff and police when a patient is missing. As the OSLE director testified, in instances where there is a missing patient, "the police chief is going to get with his director, and they are going to try and find that person." VHA Directive 2010-052 and the facility's related policy require medical center staff and VA police to take specific steps when a patient is reported missing and considered to be at risk.<sup>24</sup> This protocol includes conducting a preliminary search and, if the patient is not located, a full search, as well as documenting the incident and the staff's efforts.<sup>25</sup> Even in a preliminary search, the policy directs staff to search in adjacent stairwells.<sup>26</sup> With respect to full searches, the policy specifically mentions stairwells and other spaces covered by the preliminary search, along with additional interior and exterior spaces.<sup>27</sup> These requirements are echoed in the facility's local missing patients policy, which specifically states that the preliminary and full searches

---

<sup>24</sup> VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010; Facility Policy HM.11.12.COS, "Wandering and Missing Patients Policy," February 28, 2018. The OIG found that the veteran, if considered a patient, would have been determined to be "at risk" under the directive and facility policy. The directive indicates that it was set to expire in 2015, but it has not been rescinded or replaced. In the absence of current VA or VHA policy, the OIG considers previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue.

<sup>25</sup> VHA Directive 2010-052; Facility Policy HM.11.12.COS.

<sup>26</sup> VHA Directive 2010-052, at B-1.

<sup>27</sup> VHA Directive 2010-052, at B-1.

should include adjacent areas, such as stairwells.<sup>28</sup> Under the Bedford facility policy, the police chief “is responsible for ensuring that all efforts to locate the missing patient are made in a methodical manner . . . .”<sup>29</sup> The on-duty VA police supervisor is required to assist in the preliminary search and coordinate the full search, among other duties.<sup>30</sup>

Neither VHA Directive 2010-052 nor the medical center’s policy define “patient,” but senior facility leaders testified that patients are those who are obtaining treatment in VA-operated facilities or programs on campus.<sup>31</sup> The medical center director testified that the missing patients policy applies only to “somebody who is under [VA Care] on campus.” In contrast, veterans living in the BVQ were considered residents and not patients. The facility’s associate director testified that people living in the BVQ “may not be classified as a patient on VA grounds [because they] are just people living in a building that’s leased from the VA.” Similarly, the medical center director told OIG investigators that although “we have a policy for missing patients and what needs to be done,” the Caritas residents “can come and go as they please,” and there was no missing persons policy that covered them. The OSLE director echoed this view and opined that, if the individual who is reported missing is not a patient but merely a private person who lives in a private EUL building that just happens to be on a VA campus, then “that person would be reported to the local police and [VA police] would have no authority [or responsibility] to look for that person at all.”<sup>32</sup> The VA chief of police at the facility also testified that Mr. White was a resident and not a patient under the policy.

In this matter, the OIG has not found any evidence that VHA or VA police searched for Mr. White other than conducting brief tree-line searches. If Mr. White had been considered to be a missing “patient,” however, VA police would have been required to follow the procedures for searching for an individual as outlined in VHA Directive 2010-052 and the Bedford medical center’s local missing patients policy, which would have included searching the building’s stairwells.<sup>33</sup> In addition, the medical center director would have been notified immediately, whereas, in this matter, she was not informed of Mr. White’s disappearance until after his body was found.<sup>34</sup> As a VA police officer testified, the fact that a missing nonpatient resident is not

---

<sup>28</sup> Facility Policy HM.11.12.COS.

<sup>29</sup> Facility Policy H.M.11.12.COS, at 1.

<sup>30</sup> Facility Policy H.M.11.12.COS, at 6-7.

<sup>31</sup> VHA Directive 2010-052; Facility Policy HM.11.12.COS. VA Handbook 0730 also refers only to missing patients and not missing persons generally.

<sup>32</sup> The medical center’s chief of social work also stated that these policies apply only to missing patients and not to residents, like the veteran, who lived in the BVQ.

<sup>33</sup> VHA Directive 2010-052; Facility Policy HM.11.12.COS.

<sup>34</sup> Facility Policy H.M.11.12.COS, at Attachment F. The medical center director testified that she did not know Mr. White was missing “until he was found deceased,” but noted, “[I]f it was a missing patient, I would have known about it right away because it was a patient on our campus. This is a resident.”

covered by the policy was “one of the reasons that all that stuff was not done” in the case of Mr. White.

## **VA Is Required to Protect All Persons on VA Property and Not Only Patients**

The VA Secretary has a responsibility under federal law “to provide for the maintenance of law and order and the *protection of persons* and property on [VA] property.”<sup>35</sup> VA Directive 0730 addresses the “responsibilities for the . . . *protection of persons* and property within VA’s jurisdiction.”<sup>36</sup> VA Handbook 0730 similarly establishes the responsibilities of OSLE “in ensuring the *protection of persons* and property on Department property.”<sup>37</sup> The term “persons” is not defined in the statute or related VA policies, but there is no indication that it is intended to be limited to patients.

Mr. White resided at a facility on VA property and was last seen there prior to being reported missing.<sup>38</sup> He was entitled to basic protection in the form of VA police involvement and a search.<sup>39</sup> Not only did VA police fail to search for him, but even when requested by the Bedford police, they did not provide K-9 support for a search of the property.

The facility associate director reflected in his interview with OIG investigators that anyone missing on “VA Bedford campus, regardless of what they’re doing, regardless of if they’re inpatient, a veteran qualified to enroll in healthcare, [or,] regardless of their status,” VA police have a responsibility to respond. He opined that “it would be inherent in [the VA police department’s] responsibility to respond and assist anyone at any time, when available” regardless of whether they would be considered a patient under VHA’s Management of Wandering and Missing Patients directive. The associate director further stated, “[I]f there’s activity on VA property that would warrant assistance from VA police . . . whether it’s a missing person, a patient in distress, a local neighborhood jogger that fell on the side of the street,” he believed VA

---

<sup>35</sup> 38 U.S.C. § 901 (emphasis added).

<sup>36</sup> VA Directive 0730, *Security and Law Enforcement*, December 12, 2012, at 1 (emphasis added).

<sup>37</sup> VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000, at 1 (emphasis added). The handbook indicates that searching for missing patients is the primary purpose of VA police canine units. VA Handbook 0730, at 17.

<sup>38</sup> VA property is defined as “[I]and or buildings, owned or leased, that are under the jurisdiction of the Department of Veterans Affairs and are not under the control of the General Services Administration.” VA Handbook 0730, at E-1. The Caritas lease clearly states that VA has “jurisdiction and control” of Building 5.

<sup>39</sup> VA police testified that they were informed the Bedford police and Caritas had already searched the building and that both the Bedford police and Caritas believed he was no longer on the property. However, the district attorney’s report states that the Bedford police officer was told that Caritas had checked Mr. White’s *room* and could not locate him. It also states that the Bedford police officer did not search Building 5 in part because of COVID-19 precautions and that “Building 5 was in ‘lockdown,’ meaning that only residents and staff were granted access to the premises.” District attorney’s report, at 4.

police should respond with “intent to secure the scene, to help out, to deescalate or to seek assistance.”

Moreover, this matter illustrates the fact that restricting this duty to “patients” at a VA medical center excludes residents who live on the facility’s campus and likely also avail themselves of medical services there. In this case, Mr. White was actively enrolled in the VA healthcare system at the time of his disappearance. OIG investigators were told by the chief of social work that if Mr. White had been a resident in the Veterans Northeast Outreach Center temporary beds program—located in space in Building 5 that was subleased from Caritas and could only be accessed by walking through the BVQ—he would have been considered a missing *patient*. In fact, when the chief of social work received the email on May 13, 2020, from the Caritas COO about the missing veteran, he asked, “SRO [single-room-occupancy] Veteran, correct?” He explained to OIG investigators, “[W]e always ask the question [if] this is one of our patients in the temporary beds or is it a resident [of the BVQ, Caritas’s single-room-occupancy program] because processes are different. If . . . it was one of our temporary bed patients that’s a missing patient. . . . and we would have deferred to the policy on missing patients.” Mr. White had been a Veterans Northeast Outreach Center resident just a few months prior, and when he transitioned to the BVQ in January 2020 he lost his status as a “patient.”

### **Bedford VA Police Adopted a Local Procedure to Search for Missing Persons in the Wake of This Incident**

Shortly after Mr. White’s body was discovered, the Bedford VA police drafted a new standard operating procedure (SOP), *Bedford VAMC Missing/Endangered Persons Reaction*, which describes policies and procedures for conducting searches for missing and endangered persons at the medical center campus.<sup>40</sup> The procedure is carried out when “a person . . . disappears from the Bedford VA Medical Center [where] certain factors and conditions are present to warrant a search for the person.”<sup>41</sup> Any person is defined as “any veteran, resident, employee, and/or visitor.” Risk factors are also considered.

4. A person should be classified as a missing/endangered person when one or a combination of additional environmental and/or clinical factors may, in the judgment of a clinician, supervisor, manager, or police officer, increase the

---

<sup>40</sup> Facility VA Police Department Standard Operating Procedures Manual, chap. 6, sec. CC, “Bedford VAMC Missing/Endangered Persons Reaction,” June 2020. Although the SOP is styled as a VA medical center policy, it is a VA police procedure and not a medical center policy. The associate director of the medical center indicated that he had seen the procedure but was not familiar with the contents; in addition, the medical center director was not familiar with the procedure.

<sup>41</sup> Facility VA Police Standard Operating Procedures Manual, chap. 6, sec. CC.

person's vulnerability and risk. Conditions that might lead to this decision may include, but not be limited to the following:

- a. Weather conditions;
- b. Construction sites or other dangerous conditions exist nearby;
- c. Recent trauma, unexpected bad news, or abrupt change in clinical/mental status;
- d. Local geographic conditions increase risk;
- e. *Homelessness, in combination with other factors that create risk* [emphasis added]; or
- f. Any other reason determined to be hazardous to the person.<sup>42</sup>

The procedure directs officers to complete an incident report, a worksheet, and a search checklist, and is similar to VHA Directive 2010-052 in requiring a preliminary search of “nearby ward or clinic areas, offices and adjacent areas such as lobbies, stairwells, elevators, parking lots adjacent to the building” and, if the person is not located, then a full search.

The VA police chief testified that he created the new SOP to address the “gap” in VHA Directive 2010-052 and stated that the new procedure “gave us more leeway to assist in locating missing residents, or employees, or contractors, or even visitors.” He reported that since its creation in June 2020, the procedure has been “utilized . . . at least two times, maybe three times.” He also stated that the SOP would have applied to Mr. White if it had been in existence at the time of his disappearance.

## **Finding 1 Conclusion**

The OIG found that the Bedford VA police department's failure to undertake any meaningful effort to locate Mr. White resulted in part from the fact that he was not considered an at-risk patient under VHA Directive 2010-052. In the absence of any general guidance from VHA or OSLE regarding the obligations of VA police to search for other types of persons reported missing on VA property, the directive implies that such a duty exists only with respect to patients. The OIG concluded that this approach to public safety is inconsistent with the VA Secretary's responsibility under federal law and VA law enforcement policies to protect all persons on VA property.

---

<sup>42</sup> Facility VA Police Standard Operating Procedures Manual, chap. 6, sec. CC.

## Recommendations 1–2

1. The under secretary for health makes certain that policies and procedures are developed to require VA police, and other VHA staff as appropriate, to conduct searches for all persons who are reported missing on medical center campuses.
2. The executive director of the Office of Security and Law Enforcement updates VA Handbook 0730 with revisions clarifying VA police responsibilities with respect to searching for persons who are reported missing on VA property.

## Finding 2: VA Police Also Failed to Locate Mr. White Due to the Police Chief’s Improper Decision to Cease Patrols of the Building in which He Was Found

At the time Mr. White was reported missing, VA police were no longer patrolling Building 5 where the BVQ was located. The VA police chief had made a decision three months prior to Mr. White’s disappearance that he would not allow his staff to enter the building absent an express invitation from Caritas management.<sup>43</sup> The OIG found that the police chief’s order conflicted with federal law and VA law enforcement policies, which require VA police to patrol VA property.<sup>44</sup> It also violated the express terms of the lease between VA and Caritas, and the police chief had no authority to alter or amend it.

### In February 2020 the VA Police Chief Directed His Officers to Stop Patrolling Building 5

VA police were patrolling both the leased and unleased spaces of Building 5 at least daily prior to February 2020. OIG investigators were told that, during these patrols, it was common for officers to “do walk throughs of the area, talk to the people behind the desk, make conversation with veterans, and look through the building.” In addition, VA police commonly utilized its K-9 unit to conduct drug searches in the building. While officers did not necessarily go through each emergency exit stairwell in Building 5 during every shift, the two officers interviewed by OIG investigators indicated that they had personally patrolled the stairwell in which Mr. White was found on multiple occasions.

In November 2019 and February 2020, the VA police chief and his assistant met with members of Caritas management to address ongoing issues at the BVQ including residents’ smoking. The police chief’s assistant told OIG investigators that during these meetings the parties discussed

---

<sup>43</sup> As detailed below, there is conflicting testimony as to whether stopping patrols was at the request of Caritas, but this conflict is irrelevant as to the police chief’s legal authority to stop them.

<sup>44</sup> 38 U.S.C. § 901; VA Directive 0730, *Security and Law Enforcement*, December 12, 2012, at 1; VA Handbook 0730, at 1.

VA police patrol and access of the leased area of Building 5. A contemporaneous memorandum prepared by the police chief's assistant regarding a meeting on February 6, 2020, states that "Building 5 management does not want police searches or routine checks unless it is called for." The assistant testified that this note meant that Caritas would call VA police if "they suspected something," but would not want the police there unless they were specifically requested.

Two officers testified that shortly after this meeting, they received orders from the police chief (both verbally and in emails) instructing them not to enter Building 5 without prior permission from Caritas management unless they were responding to an active emergency. Additionally, in a February 10, 2020, email to members of the VA police K-9 team, the VA police chief stated, "As a reminder it is not within our authority to conduct . . . walkthroughs of [Building 5] without being invited by [Building 5] management."

Contrary to these contemporaneous records provided by VA police, the Caritas house manager and the COO both denied in their interviews with OIG staff that they had requested a reduction in patrols or reached any agreement to that effect with VA police. In fact, the COO testified that he was surprised to hear about this, and he said that they "wanted to work as partners." He further stated, "We were the ones who reached out and to hear that they were not coming by and they chose not to come by, it's, it's a pity. Maybe things would have been different." It was not necessary for the OIG to resolve this inconsistent testimony because the OIG's findings focus on the police chief's lack of legal authority to cease patrols; the reason for his decision does not affect that analysis.

As a result of the police chief's instruction, VA police patrols of Building 5 ceased.<sup>45</sup> According to an officer interviewed by OIG staff, the chief's order applied not only to the Caritas leased space but also to the other portions of Building 5 that were not leased and remained under VA's control, such as the VA first-floor office space and the emergency exit stairwells.<sup>46</sup> As one officer testified, VA police effectively "had no access to the building," and "we were . . . told to pretty much stay away." There were no routine patrols of any part of Building 5 in the weeks preceding or following Mr. White's disappearance in May 2020, including the emergency exit

---

<sup>45</sup> While VA police patrol logs for the period February 2020 through June 2020 appear to indicate police activity both inside and outside of Building 5, the OIG was informed that the entries recorded in the logs were imprecise. One of the VA police officers interviewed testified that terms contained in the patrol logs such as "check" and "walkthrough" were used interchangeably. For example, a check of the exterior of Building 5 could be referred to as a "walkthrough" even though the officer did not physically enter Building 5. Additionally, this officer indicated that the term "Building 5" did not always mean the entirety of Building 5, but it could mean a subsection of the building such as the tunnel below the building. As a result of these ambiguities, these logs could not be fully relied on to determine the scope of patrols conducted in Building 5.

<sup>46</sup> As previously mentioned (and figure 1 indicates), Caritas subleased part of its space in Building 5 to Veterans Northeast Outreach Center, which provided temporary and transitional housing to veterans pursuant to a contract with VA.

stairwells. An officer told OIG investigators that had VA police been patrolling Building 5 at the time of his disappearance, he believed they would have “absolutely” seen Mr. White, and he would have been located significantly sooner.<sup>47</sup>

### **The Police Chief’s Decision Violated VA Policy Requiring Patrols of All VA Property, Including the Emergency Exit Stairwell**

VA police are responsible for patrol services and law enforcement duties on VA property.<sup>48</sup> With respect to the Bedford medical center, VA police are required to provide patrols and emergency service for all VA buildings on the Bedford campus, including the portions of Building 5 not included in the Caritas lease.<sup>49</sup> In addition, VA Handbook 0730 states that on VA property VA police are responsible for “vigorous and inquisitive patrol activity that will provide the greatest frequency of visibility in corridors, wards, stairwells and building perimeters.”<sup>50</sup>

As noted previously, Building 5 contained both leased (the BVQ) and unleased spaces (VA office space located on part of the first floor). In addition, part of the BVQ space was leased by Caritas to another nonprofit, the Veterans Northeast Outreach Center, that provided temporary and transitional beds to veterans experiencing homelessness pursuant to a contract with VA. With respect to the Caritas lease, it indicates that the emergency exit stairwells were not leased to Caritas and instead remained VA property. Specifically, the lease contains a drawing indicating, with shading, the areas leased by Caritas, and the emergency exit stairwells are not shaded. VA’s Office of General Counsel conducted a follow-up review of the lease in the wake of Mr. White’s death and confirmed that the emergency exit stairwells are not part of the space leased to Caritas.

Because Building 5 contained unleased spaces, VA police were responsible for patrol and emergency response for this area under Handbook 0730. The director of OSLE confirmed the VA police chief lacked the authority to stop patrols of the inside of any VA property per VA Handbook 0730, including the emergency exit stairwells. Specifically, the OSLE director testified that, if a property is owned by VA, a VA police chief “has no authority to say he’s not going to do any patrols” inside any VA property. Also, according to the OSLE director, where

---

<sup>47</sup> When the medical center associate director learned shortly after Mr. White’s remains were discovered that the chief of police had stopped patrols of the leased area, the associate director requested that the patrols be resumed. On June 17, 2020, the VA police chief reinstated patrols of Building 5, including the leased area of the building as well as emergency exit stairwells.

<sup>48</sup> 38 U.S.C. § 902(a)(1); VA Handbook 0730.

<sup>49</sup> VA Handbook 0730. The Bedford VA police procedures manual indicates that officers “shall patrol the medical center roadways, grounds, common areas and buildings on a non-standard schedule” and does not distinguish between spaces that are leased or used by VA. Facility VA Police Standard Operating Procedures Manual, chap. 11, sec. E, “Specific Shift Duties and Responsibilities.”

<sup>50</sup> VA Handbook 0730, at 14.

only part of a building is leased, like Building 5, the VA police chief should be aware of exactly what is VA property in order to appropriately patrol VA spaces.

Although OIG investigators were unable to determine if the police chief had ever reviewed the lease, the police chief should have known that the stairwell was VA property well before Mr. White's disappearance, as the medical center's director of social work emailed him on March 23, 2020, and indicated that the stairwells and exterior doors were not part of the leased area.<sup>51</sup> In addition, the police chief testified that he was aware of the VA temporary bed program in Building 5. VA's OSLE director remarked that, in his professional opinion, a police chief should be familiar with any leased property on the medical center campus and what police responsibilities are to that building. He further testified that "if you've got a chief out there that doesn't know the peculiarities" of where they are required to patrol, "the chief's not doing his job."

### **The Police Chief's Decision Also Contravened the Express Terms of the Lease, Which He Lacked Authority to Amend**

The express terms of the Caritas lease assign the VA police responsibility for "police patrol and protection . . . and emergency services to the Property." While the lease indicates that VA police and the Bedford police share concurrent jurisdiction over the leased area of Building 5, it also specifically states that first calls for assistance should go to VA police and includes the VA police emergency and nonemergency phone numbers directly after this instruction.

When the VA police chief decided to stop the patrols of the leased space within the building, he violated the terms of the lease for which he had no authority to alter or amend. The terms of EULs can be changed only through a formal process in which OAEM first reviews the proposed terms of a lease in conjunction with VA's Office of General Counsel. OAEM is responsible for establishing policies, procedures, and guidelines relating to EULs and for overseeing compliance.<sup>52</sup> According to an OAEM oversight monitor, any proposed lease amendment, which must be in writing, is submitted to an assistant secretary for approval and signature. After the lease amendment is ratified, the changes to the lease are memorialized in the EUL's project folder. OIG investigators found no evidence that OAEM or the Office of General Counsel were

---

<sup>51</sup> As mentioned earlier, the VA police chief asked to end his interview before its completion because of health issues, so OIG investigators were unable to question him about this email.

<sup>52</sup> VA Directive 7415, *Enhanced-Use Lease Program Policies*, September 29, 2017.

ever consulted about this change, and the only recorded amendment to the Caritas lease was in 2006.<sup>53</sup>

## **Finding 2 Conclusion**

VA police did not discover Mr. White's remains in the stairwell during the month after he was reported missing because they were no longer patrolling Building 5. Prior to the VA police chief's order that all patrols cease, the officers were entering the stairwell space on a periodic basis. The OIG found that the VA police chief exceeded his authority in issuing this order, which contravened both VA policy requiring patrols of VA property and the express lease terms.

## **Recommendation 3**

3. The assistant under secretary for health for operations, in consultation with the VA chief security officer, requires VA police chiefs at medical centers to obtain approval from the facility associate director or the medical center director prior to excluding a building or area of the medical center's campus from regular patrols, and, if the building or area is subject to an enhanced-use lease, confirms with the Office of Enterprise Asset Management and the Office of General Counsel that the exclusion is not in conflict with the terms of the lease.

## **Finding 3: Inadequate OAEM Oversight and Guidance Regarding the Caritas Lease Contributed to Confusion over VA's Responsibility for Cleaning Building 5's Emergency Exit Stairwells**

As a result of a mistaken belief that Building 5's emergency exit stairwells were part of the space leased by Caritas, medical center staff did not clean the stairwells prior to the discovery of Mr. White's remains. The OIG found that the confusion among medical center leaders and staff regarding the nature and extent of the Caritas lease stemmed from a lack of clear guidance regarding the terms of the lease and VA's obligations. OAEM was established to provide support to VA organizations regarding EULs and ensure compliance with lease terms. The OIG found that OAEM did not follow its own procedures with respect to providing oversight and that, in certain respects, its procedures were inadequate to detect and resolve the issues that arose with the Caritas lease.

---

<sup>53</sup> The OAEM executive director told OIG investigators that VA police are permitted to enter into agreements and memorandums of understanding with private entities relating to leased properties without consulting OAEM and VA's Office of General Counsel, but these agreements cannot contravene the terms of the lease. If such an agreement is later determined to conflict with the lease terms, only the lease terms would be recognized by VA.

## **Building 5's Emergency Exit Stairwells Were Not Cleaned Due to a Misunderstanding Regarding the Lease Scope**

VHA's Environmental Management Service (EMS) is responsible for the cleanliness of the medical facilities, among other duties. Each VA facility, including at Bedford, has a chief of EMS who reports to the medical center's associate director.<sup>54</sup> At Bedford, EMS cleaned emergency exit stairwells of nonleased VA buildings on the medical center campus. In addition, the facility even had a local operating procedure that provided specific instructions on the proper method for cleaning stairwells.<sup>55</sup> The EMS chief testified that he himself "physically check[s]" those [nonleased] stairwells "several times a week."

In contrast, however, EMS did not clean leased spaces on the medical center campus. The Bedford EMS chief told OIG investigators that since he took over this position in 2014, EMS had never cleaned any part of the leased area of Building 5. In addition, Building 5 was not included in the Environment of Care Rounds, which are periodic facility tours that are conducted to detect unsafe and/or untoward conditions and determine whether the facility's processes for managing environmental care are practiced correctly and effectively.<sup>56</sup>

The EMS chief testified that it was "common knowledge" that Building 5 contained leased space and that his predecessor told him "not to be concerned" about it. The EMS chief further stated that his staff did not clean the emergency exit stairwells in Building 5 because he believed EMS did not have access due to the lease. As noted previously, however, the emergency exit stairwells were not part of the Caritas space under the lease, and they remained VA property.

The associate director of the medical center told OIG investigators that, after the discovery of Mr. White's body in the stairwell, he requested that the stairwells be cleaned. EMS is now cleaning Building 5's emergency exit stairwells four times per week.

## **VA Policies Required OAEM to Oversee the Caritas Lease and Appoint a Local Site Monitor**

OAEM is responsible for the management and oversight of VA's EUL program.<sup>57</sup> EULs are public/private partnerships between VA and developers through which VA leases underutilized land or buildings to third parties, such as Caritas, to be developed into housing for veterans

---

<sup>54</sup> VHA Directive 1850, *Environmental Programs Service*, March 31, 2017.

<sup>55</sup> Environmental Management Service (137), Procedure No. E-26, *Stairwell Cleaning*, October 2014.

<sup>56</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

<sup>57</sup> VA Directive 7415.

experiencing homelessness.<sup>58</sup> In particular, OAEM ensures that lessees are operating in accordance with the lease requirements.<sup>59</sup>

VA created specific roles for individuals employed at both OAEM and at VA facilities to provide guidance and oversight for EULs. The real property group within VA's Office of General Counsel is responsible for providing legal guidance on all matters relating to EULs.<sup>60</sup> Within OAEM, two oversight monitors divide up VA's portfolio of approximately 80 EULs. In addition, VA delegates certain on-site compliance monitoring to an appointed local site monitor (LSM).<sup>61</sup> The oversight monitors are responsible for "overseeing the compliance monitoring performed by the . . . LSMs."<sup>62</sup>

The LSM is responsible for on-the-ground management of the lease, and, according to the OAEM director, "is responsible for making that first line connection with the lessee."<sup>63</sup> VA Handbook 7454 tasks LSMs with "day-to-day post-transaction compliance monitoring"—that is, ensuring lessee and VA compliance with the terms of the EUL and overseeing operational activities to ensure the lessee is performing in accordance with EUL terms and conditions.<sup>64</sup> The OAEM director testified that he expected LSMs to be familiar enough with Handbook 7454 to at least be able to generally articulate their responsibilities. In addition, he stated that LSMs should be familiar with the actual lease because "every lease is unique in some of the requirements within it, and the lease could have requirements for either VA to fulfill certain obligations, or the lessee to fulfill certain obligations, [so] we're looking for the LSM to be able to actually confirm that those things are happening."

He further explained that the LSM is the first VA point of contact at an EUL site if there are any questions regarding the lease. For example, if a chief of maintenance had a question about whether staff should be cleaning an EUL building, the LSM would be the appropriate contact person. Additionally, a police chief or a medical center director should be able to consult with the LSM for information on whether an EUL space is VA's responsibility. Directive and Handbook 7454 both imply that LSMs must review the leases to perform their duties properly, as

---

<sup>58</sup> VA OAEM, "Enhanced-Use Lease Program Fact Sheet," March 27, 2019, <https://www.va.gov/assetmanagement/docs/overviewEulProgram.pdf>.

<sup>59</sup> VA Directive 7415, at 4.

<sup>60</sup> VA Directive 7415, at 9.

<sup>61</sup> VA Handbook 7454, *Enhanced-Use Leasing Post Transaction*, June 29, 2012, at G-7.

<sup>62</sup> VA Handbook 7454, at G-10.

<sup>63</sup> VA Handbook 7454, at G-7.

<sup>64</sup> VA Handbook 7454, at G-7. On an annual basis, the LSM is tasked with determining whether the lessee is complying with certain aspects of the lease, referred to as the Annual Oversight Compliance Certificate. As part of this process, the LSM collects specific financial and insurance documentation from the lessee and reports this information back to OAEM. VA Handbook 7454, at 20.

both require the LSM to exercise judgment and make determinations that would require an understanding of the lease terms.<sup>65</sup>

### **Because OAEM Did Not Properly Designate the LSM, Information on Responsibilities Was Not Shared**

Because EULs can last up to 75 years, turnover among VA personnel and lessee representatives during the lease term is expected, and VA Handbook 7454 requires written notification be made to OAEM of any changes in the LSM.<sup>66</sup> When an LSM is formally designated, they are provided a signed memorandum by OAEM detailing their responsibilities. This memorandum also specifically indicates that the LSM duties are outlined in VA Handbook 7454.

The medical center's chief of engineering assumed the role of LSM for the Caritas lease in December 2017 when the former LSM, the assistant chief of engineering, left VA. The OAEM oversight monitor for the Caritas lease reached out to him to inquire about a replacement LSM, and the chief of engineering indicated that he would assume the role until a replacement was hired for the assistant chief. The chief of engineering has remained in that acting role since 2017, but he was never formally designated as LSM by OAEM or provided a signed memorandum until March 2021, nearly four years after he became the acting LSM and nine months after Mr. White's body was found in the stairwell.<sup>67</sup>

If the LSM had received a designation memorandum, he would have been informed about VA Handbook 7454, which outlines the role and responsibilities of the LSM, including an LSM's responsibility to ensure lease compliance. When asked if he had reviewed VA Handbook 7454, the LSM stated that he had never seen it before and was not familiar with its contents. The LSM testified further that he did not receive a copy of the lease or Handbook 7454 from OAEM, the medical center director, or the medical center associate director when he became the acting LSM. In addition, from the time he assumed the role of LSM in December 2017 until Mr. White was found deceased in June 2020, the LSM never reviewed the lease. While the LSM told OIG investigators that he attended OAEM training for LSMs in 2018, 2019, and 2020, he indicated that the training was the same each year and focused on how to upload documents to the designated EUL SharePoint site.

---

<sup>65</sup> VA Directive 7454, *Enhanced-Use Leasing Post Transaction Policies*, June 29, 2012, at 6; VA Handbook 7454, at A-12.

<sup>66</sup> VA Handbook 7454, at 42.

<sup>67</sup> In July 2020, when the medical center associate director requested a copy of the formal designation letter from the oversight monitor, he was provided the designation letter for the acting LSM's predecessor dated April 2017. OAEM did not prepare a draft designation memorandum for the subsequent LSM until January 2021, which was finalized on March 24, 2021.

As a result, the LSM misunderstood the terms of the lease and the boundaries of the Caritas space. Like the EMS chief, the medical center associate director, and the medical center director, the LSM testified that prior to the discovery of Mr. White's remains, he had believed that the emergency exit stairwells were not VA's responsibility. He indicated that his understanding was based on information he obtained from VA police, including that VA police did not patrol Building 5, along with his knowledge regarding the medical center staff's limited access to the space.<sup>68</sup>

In addition, the LSM's understanding of his role was much narrower than contemplated in Handbook 7454. According to the LSM, his primary duty was that of the chief engineer, and his LSM role was "a collateral duty . . . not something we do day in and day out." This view does not align with the "day-to-day" nature of the monitoring described in the handbook, which underscores that the OAEM had not properly trained or informed the LSM regarding his responsibilities.<sup>69</sup>

The OIG found that the LSM was never in a position to be an on-the-ground resource for medical center staff regarding the Caritas lease, as contemplated by VA policy, or to clear up the persistent confusion regarding the lease footprint and the parties' respective obligations. The OIG also found that OAEM's procedures for designating and training new LSMs was inadequate, as they do not include providing LSMs with a copy of the relevant leases or Handbook 7454 or substantive training. The facility associate director compared the situation to "somebody being a representative of a contract in the acquisitions world without knowing the parameters of what they can and cannot obligate the government in." He further stated that it "put the agency at risk because the LSM really doesn't know the responsibilities of the [position]." The medical center director echoed these same concerns in her testimony as well. Moreover, if VA, through the LSM and OAEM, is not exercising effective oversight of its EULs, VA also risks jeopardizing the success of the EUL program and the at-risk veterans that it is designed to serve.

### **Finding 3 Conclusion**

The OIG found that VA failed to ensure that key medical center staff had a clear understanding of what the Caritas lease said, their responsibilities under the lease, and the actual boundaries of the leased space. Specifically, the lack of proper designation of the role of LSM at the Bedford

---

<sup>68</sup> The only manager at the facility interviewed by OIG staff who had read or was familiar with the lease prior to Mr. White's death was the chief of social work. He testified that although there was "no official role" for him as it related to the lease, he was acting as "liaison for leadership here at the facility if there was concerns or questions about something that might have happened in Building 5." In addition, he stated that he first read the lease in either 2015 or 2016 when someone at the medical center asked about "the stipulations of the lease and what the responsibilities were of all parties."

<sup>69</sup> VA Handbook 7454, at 9.

medical center not only violated VA Directive 7454 but also contributed to the LSM's misunderstanding of his role and responsibilities and contributed to confusion at the facility regarding the terms of the Caritas lease. In addition, policies and procedures examined during this investigation place the impetus on service chiefs at VA medical centers to request information from an LSM or OAEM regarding VA's responsibilities with respect to leased spaces. If the LSM, along with medical center leaders, the VA police chief, and the EMS chief, had a better understanding as to the terms of the Caritas lease, it is likely that VA would have been cleaning the emergency exit stairwells at the time of Mr. White's disappearance and would have found him earlier.

### **Recommendations 4–7**

4. For all medical centers that have property subject to enhanced-use leases, the assistant under secretary for health for operations, in consultation with the VA chief security officer, requires the medical center director or the director's designee to meet with the assigned oversight monitor at the Office of Asset Enterprise Management, the designated local site monitor, and a representative of the Office of General Counsel at least annually—or sooner if there is a change of lease terms or facility leadership—to discuss the terms of the enhanced-use leases and the lessee's and VA's responsibilities with respect to the leased properties.
5. The executive director of the Office of Asset Enterprise Management includes a copy of the lease and VA Handbook 7454 with the designation memorandum sent to newly appointed lease site monitors.
6. The executive director of the Office of Asset Enterprise Management, in conjunction with the Office of General Counsel, reviews all active enhanced-use leases to determine whether any involve portions of buildings also occupied by VA, and, if so, whether they are clear regarding the maintenance and security obligations.
7. The executive director of the Office of Asset Enterprise Management modifies its existing Annual Oversight Compliance Certificate policies to include a review of VA's performance with respect to any services VA is required to provide under the terms of enhanced-use leases.

## Conclusion

The OIG found that Mr. White's disappearance did not receive the attention it deserved from VA, an agency that is required by federal law to provide for the protection of all persons on its property. The events surrounding Mr. White's disappearance revealed several deficiencies in VHA and VA policies regarding missing persons on VA properties, local policing decisions, and oversight of enhanced-use leases. The medical center, including its VA police, did not initiate a response to Mr. White's disappearance under VHA's missing patients policy because he was considered a resident and not a patient. In addition, poor decision-making, misinformation, and lack of oversight also prevented anyone at VA from encountering Mr. White during the month after he was reported missing through routine patrols or cleaning of the emergency exit stairwell in which his body was found. Although the OIG was unable to point to a single responsible individual, office, or decision, each of these deficiencies contributed to VA's failure to locate Mr. White.

In response to this report, the acting under secretary for health, the executive director of OSLE, and the executive director of OAEM provided written comments in which they concurred with the OIG's findings and recommendations. They provided action plans to implement the recommendations, which the OIG will closely monitor. The OIG also received comments from the Veterans Integrated Service Network 1 (VISN 1) director that oversees the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts, although he was not requested or obligated to do so because none of the recommendations were directed to him. The VA responses and the VISN 1 director's written comments are published in their entirety as appendix B, followed by the OIG's reply to the VISN 1 director's remarks.

## **Appendix A: Scope and Methodology**

### **Scope**

The OIG's review period for this administrative investigation spanned from November 2019 through April 2021. (See scope limitations below regarding paused interviews during the criminal investigation.)

### **Methodology**

OIG investigators conducted 33 interviews of 24 individuals. Specifically, the OIG team interviewed the following medical center leaders and its police and other staff: the police chief, the director, the associate director, the chief of engineering, the chief of social work, the mental health service line manager, and VA police officers. The OIG team also interviewed the director of OSLE, Office of General Counsel attorneys, other current and former VA employees, and Caritas staff. The team reviewed VA email records, official personnel records, and other documentation received from VA and VHA staff in response to document requests. OIG investigators also reviewed applicable laws and regulations and relevant VA policy, procedures, guidance, and directives.

Consistent with the Privacy Act and OIG policy, the OIG removes identifiers in its reports for individuals when necessary to protect the privacy and identity of involved parties and witnesses where those privacy interests outweigh the public interest in disclosure. Although the OIG generally does not find that the public interest outweighs a veteran patient's privacy interests, the OIG made a different decision with respect to Mr. White in this report because he was previously publicly identified in the district attorney's report, as well as in media reports regarding his death. Inclusion of his name allows the OIG to clearly and respectfully recognize Mr. White.

### **Scope Limitation**

The OIG based its conclusions on available evidence. The VA police chief resigned effective February 12, 2021, citing health concerns. The OIG team was able to conduct a partial interview with the police chief on February 3, 2021, prior to his resignation, but he was unable to complete the interview due to health concerns. The former police chief declined to complete the interview on a later date, which limited the OIG team's ability to reconcile conflicting testimony. Further, the OIG delayed administrative interviews for several months due to the ongoing district attorney's office investigation. Once the district attorney issued its report, the OIG team proceeded with interviews and completed its own investigation of the circumstances surrounding Mr. White's death and VA's failure to locate him.

### **Government Standards**

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Investigations*.



## Appendix B: Management Comments and OIG Response

### Response of the Acting Under Secretary for Health

#### Department of Veterans Affairs Memorandum

Date: July 8, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus (2020-03465-SR-0588) (VIEWS #5398545)

To: Director, Office of Special Reviews, Office of Inspector General (OIG)

Thank you for the opportunity to review and comment on the Office of Inspector General's draft report. We extend our condolences to the family and friends of this patient and are deeply saddened by this loss. The Veterans Health Administration concurs with recommendations 1, 3, and 4 and provides the attached action plan.

Responses to recommendations 2, 5, 6 and 7 are provided by the Department's Office of Security and Preparedness/Office of Security and Law Enforcement and the Office of Asset Enterprise Management.

Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [REDACTED].

(Original signed by:)

Richard A. Stone, M.D.

Attachments

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

VA HEALTH CARE: *Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus*  
(Project Number 2020-03465-SR-0588)

Date of Draft Report: June 11, 2021

---

Recommendations/Actions	Status	Completion Date
-------------------------	--------	-----------------

---

**Recommendation 1. The Under Secretary for Health makes certain that policies and procedures are developed to require VA police, and other VHA staff as appropriate, to conduct searches for all persons who are reported missing on medical center campuses.**

**Comments:** Concur

The Veterans Health Administration (VHA) Office of the Assistant Under Secretary for Health (AUSH) for Operations, the Office of Security and Preparedness/Office of Security and Law Enforcement (OSP/OSLE) are collaborating to draft a new Standard Operating Procedure (SOP) that identifies responsibilities of police and other Department of Veterans Affairs (VA) staff to conduct searches for persons reported missing on VA medical center campuses.

**Status:** In progress

**Target Completion Date:** October 2021

**Recommendation 3. The Assistant Under Secretary for Health for Operations, in consultation with the VA Chief Security Officer, requires VA police chiefs at medical centers to obtain approval from the associate director or the medical center director prior to excluding a building or area of the medical center's campus from regular patrols, and, if the building or area is subject to an enhanced-use lease, confirms with the Office of Enterprise Asset Management and the Office of General Counsel that the exclusion is not in conflict with the terms of the lease.**

**Comments:** Concur

VHA's Office of the AUSH for Operations and OSP/OSLE are collaborating to draft a new SOP that identifies responsibilities of police and other VA staff to conduct searches for persons reported missing on VA medical center campuses. The new SOP will address the requirement for VA police chiefs at VA medical centers to obtain approval from the Associate Director, the Medical Center Director (MCD), or appropriate delegated facility official prior to excluding a building or area of the VA medical center's campus from regular patrols, and, if the building or area is subject to an enhanced-use lease (EUL), confirm with the Office of Enterprise Asset

Management (OAEM) and the Office of General Counsel (OGC) that the exclusion is not in conflict with the terms of the EUL.

**Status:** In progress

**Target Completion Date:** October 2021

**Recommendation 4. For all medical centers that have property subject to enhanced-use leases, the Assistant Under Secretary for Health for Operations, in consultation with the VA Chief Security Officer, requires the medical center director or the director's designee to meet with the assigned oversight monitor at the Office of Asset Enterprise Management, the designated local site monitor, and a representative of the Office of General Counsel at least annually—or sooner if there is a change of lease terms or facility leadership—to discuss the terms of the enhanced-use leases and the lessee's and VA's responsibilities with respect to the leased properties.**

**Comments:** Concur

VHA's Office of the AUSH for Operations and OSP/OSLE are collaborating to draft a SOP that identifies responsibilities of police and other VA staff to conduct searches for persons reported missing on VA medical center campuses. The requirement for the MCD or the director's designee to meet with the assigned oversight monitor at the OAEM, the designated local site monitor, and a representative of OGC at least annually—or more frequently if there is a change of lease terms or facility leadership—to discuss the terms of the EULs and the lessee's and VA's responsibilities with respect to the leased properties will be addressed in the new SOP.

**Status:** In progress

**Target Completion Date:** October 2021

## **Response of the Office of Security and Law Enforcement**

### **Department of Veterans Affairs Memorandum**

Date: July 2, 2021

From: Senior Executive Director, Office of Security and Law Enforcement (OS&LE)

Subj: Draft Report, Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus, (2020-03465-SR-0588) (VIEWS #5398545)

To: Director, Office of Special Reviews, Office of Inspector General (OIG)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Failure to Locate Missing Veteran Found Dead. The Office of Security and Preparedness and the Office of Security and Law Enforcement (OSP/OSLE) concurs with recommendations 2 and include an action plan and a target completion date.
2. OSP/OSLE will work with Veterans Health Administration Senior Security Officer to ensure a new model Standard Operating Procedure is published.
3. I appreciate the opportunity to review and respond to the draft report and look forward to the resulting improvements.

(Original signed by:)

Frederick Jackson

Attachment

ATTACHMENT

**RECOMENDATION AND THE OFFICE OF SECURITY AND PREPAREDNESS  
AND THE OFFICE OF SECURITY AND LAW ENFORCEMENT (OSP/OSLE)  
IMPLEMENTATION PLAN**

**Recommendation 2. OSP/OSLE Concur**

**The Executive Director of the Office of Security and Law Enforcement updates VA Handbook 0730 with revisions clarifying VA police responsibilities with respect to searching for persons who are reported missing on VA property.**

**OSP/OSLE Implementation Plan:**

Action: OSP/OSLE is drafting a new Standard Operating Procedure (SOP) clarifying responsibility of the VA police, with respect to searching for persons who are reported missing on VA property, and referencing enhanced-use lease. The new SOP will become part of the records control system and will be coordinated with VHA Senior Security Officer.

Status: In progress    Target Completion Date: October 2021

## **Response of the Office of Asset Enterprise Management**

### **Department of Veterans Affairs Memorandum**

Date: June 29, 2021

From: Executive Director, Office of Asset Enterprise Management (OAEM)

Subj: Draft OIG Report, *Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus*, Project No. 2020-03465-SR-0588

To: Director, Office of Special Reviews, Office of Inspector General (OIG)

1. I have reviewed the subject draft OIG report. OAEM concurs with each of the recommendations for OAEM (Recommendations 5, 6 and 7) and have included action plans to implement each of recommendations, including target completion date.
2. I have also included context on the Enhanced Use Lease (EUL) program and how it differs from the Bedford Veterans Affairs Medical Center (VAMC) operations.
3. I appreciate the opportunity to review and respond to the draft report and look forward to the resulting improvements in the Enhanced Use Lease program.

(Original signed by:)

Christopher Brett Simms

Attachment

ATTACHMENT

**OAEM RESPONSE TO FINDING 3 AND ADDITIONAL CONTEXT**

OAEM concurs with finding 3 and provides the below additional context and information in response.

The Department of Veterans Affairs (VA) Enhanced-Use Lease (EUL) program is separate and distinct from other Bedford VAMC activities. The EUL program is an important component of both VA's mission to end Veteran homelessness and the Department's overall asset management program. Through this program, VA out-leases underutilized real estate under its jurisdiction or control to the private sector for up to 75 years; for the purpose of developing supportive housing for homeless and at-risk Veterans and their families. Through this innovative portfolio management tool, Veterans are provided with an expanded range of housing and services that would not otherwise be available on medical center campuses.

The City of Bedford, MA recognized the acute need for safe, affordable housing for the homeless Veteran population in greater Boston, where the only affordable housing available is often in unsafe areas where alcohol and drug abuse are widespread; which is unsuitable for Veterans who are in recovery and need a supportive living arrangement. Through this EUL, the Lessee (Caritas Communities) is responsible for rehabilitation, maintenance, repair, and operations on the first and second floors, of a 60-unit Single Room Occupancy (SRO) permanent housing facility in "Building 5." This project provides safe, supportive, and affordable housing to mentally ill, disabled, and single adult homeless Veterans. All services offered are exclusive to eligible Veterans.

Caritas Communities, Bedford VAMC and OAEM acknowledged the joint responsibility for ensuring compliance with all applicable Federal, State and Local laws, regulations, or requirement during operation of the property. The Lease specifically covers everything from means of egress, features of fire protection, and emergency communications. The Bedford VAMC police is responsible for providing police patrol and protection, fire protection and inspections, and emergency services to the property. Caritas Communities, as the Lessee, is required to use all reasonable and commercial efforts to ensure the EUL facility operates in a safe and secure manner; and activities do not negatively affect the operations conducted by the VAMC, including the monitoring of associated access to building.

ATTACHMENT

**RECOMMENDATIONS AND OAEM IMPLEMENTATION PLANS**

**Recommendation 5: OAEM Concurs**

The Executive Director of the Office of Asset Enterprise Management includes a copy of the lease and VA Handbook 7454 with the designation memorandum sent to newly appointed lease site monitors (LSM).

OAEM Implementation Plan

Action: OAEM will include, as attachments to each LSM designation letter, a copy of the executed lease, including exhibits, and VA Handbook 7454. Email alerts will be sent to all LSM's verifying VAMC access to SharePoint site w[h]ere the handbook and leases, including exhibits are stored. The LSM designation letters have already been modified to include a link to Handbook 7454 and executed lease, including exhibits stored on the EUL SharePoint site (EULIS).

Target completion date: September 30, 2021

**Recommendation 6: OAEM Concurs**

The Executive Director of the Office of Asset Enterprise Management, in conjunction with the Office of General Counsel, reviews all active enhanced-use leases to determine whether any involve portions of buildings also occupied by VA, and, if so, whether they are clear regarding the maintenance and security obligations.

OAEM Implementation Plan

Action 1: OAEM will validate with OGC the previously conducted study to confirm the finding that there are no other active residential EULs wherein a single building is partially EUL and partially VA operated.

Target completion date: September 30, 2021

Action 2: OAEM will review all active EULs to identify those that involve EUL buildings where agreements are in place for VA to utilize a portion of the EUL building, but the full building is still subject to the EUL. OAEM will determine whether the lease language is clear regarding maintenance and security obligations in those situations and will validate all results with OGC.

Target completion date: October 31, 2021

**Recommendation 7: OAEM Concur**

The Executive Director of the Office of Asset Enterprise Management modifies its existing Annual Oversight Compliance Certificate policies to include a review of VA's performance with respect to any services VA is required to provide under the terms of enhanced-use leases.

OAEM Implementation Plan

Action. OAEM will update the annual Oversight Compliance Certificate (AOCC), Outcome Tracking Sheet (OTS) and Site Visit Checklist templates for each project to include status of VA's performance with respect to services VA is required to provide under the EUL. This field will be populated in the upcoming AOCC report covering FY 2020.

Target completion date: December 31, 2021

## Response of the VA New England Healthcare System

### Department of Veterans Affairs Memorandum

Date: July 1, 2021

From: Network Director, VA New England Healthcare System (10N1)

Subj: Draft Report, Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus, (2020-03465-SR-0588) (VIEWS #5398545)

To: Director, Office of Special Reviews, Office of Inspector General (OIG)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Failure to Locate Missing Veteran Found Dead. The Veterans Health Administration (VHA) concurs with the recommendations and provides action plans in the attachment. We also again reiterate our condolences to the White family on the unfortunate delay in locating Mr. White after he was reported missing.

2. While VHA concurs with each recommendation of the OIG, it is important to note several contextual factors that are missing or incomplete from the OIG report. I believe that a more thorough discussion of these issues will yield a better public understanding of the nature of this event. First, the OIG focused a significant part of their review on clarifying the appropriate “owner” of the stairwell where Mr. White was found. While we agree that it is important to clarify this issue moving forward, as it relates to the unfortunate delay in locating Mr. White, the issue of who “owns” the stairwell is a distinction without a difference. Veterans Affairs (VA) and Caritas personnel each had access to the stairwell for the purposes of conducting a search at any time, and access could and would have been granted to any other individual or entity at any time if there was any reason to believe that this was where Mr. White may be located. Any implication that lack of clarity on who owned the stairwell somehow prevented searching that area is false.

3. Regarding the role of the VA Police in this search, VHA agrees that it is unfortunate that a search of the stairwell was not immediately conducted upon learning of Mr. White being reported as missing. However, a common sense reading of the situation, supported by testimony of VA Police officers involved in the case, suggests that both Bedford Town Police and Bedford VA Medical Center Police were each operating under an assumption that the entire building had already been searched by Caritas personnel. It is unclear from the OIG report if the OIG did not question Caritas staff more thoroughly on what steps were taken to locate Mr. White, or if the OIG elected to not include a summary of these actions in the report. The general public would benefit from a more thorough understanding of this issue, including a description of what steps Caritas took, whether any videotape footage of Building 5 was reviewed by Caritas, and any reasons that all common areas such as stairwells were not searched.

4. A final piece of context regarding this case is the friction that exists on any VA campus housing an Enhanced Use Lease (EUL) housing project. Specifically, individuals living in such arrangements are considered to be equivalent to private citizens in their own apartment as it relates to VA Police presence. While the OIG cites in their report the need for VA Police to have a presence in all space on VA campuses, the fact remains that there is a stark difference in VA policing of EUL spaces and VA operated spaces. For example, a VA Police officer may patrol or enter any inpatient med/surg room or Community Living Center room on a VA campus at the discretion of the officer. VA Police frequently and routinely patrol common areas in such settings as well. Such expectations do not generally exist in EUL spaces, where VA Police are often bound by the EUL with various restrictions, such as advance notice of intent to enter the premises, or specific language stating that VA Police will **not** routinely patrol common areas inside the EUL. While OIG found that the stairwells were the responsibility of VA Police, the only way to enter those stairwells was through the Bedford Veterans Quarters space, and VA Police were sensitive to the need to respect the privacy of the residents of the EUL by not frequently walking through their living space.

(Original signed by:)

Ryan S. Lilly, MPA  
Network Director  
VA New England Healthcare System, (10N1)

## OIG Response

The OIG requested written responses to the findings and recommendations in this report from the persons to whom the recommendations were directed. These were the acting under secretary for health, the executive director of the Office of Security and Law Enforcement, the assistant under secretary for health for operations, and the executive director of the Office of Asset Enterprise Management. The relevant officials concurred with the OIG's findings and recommendations and provided action plans to implement the recommendations, which the OIG follow-up team will track and request quarterly progress updates.

The OIG also received a response from the Veterans Integrated Service Network 1 (VISN 1) director, although he was not requested or obligated to provide a response to the report because none of the recommendations were directed to him. While the VISN 1 director acknowledged VHA's concurrence, he also volunteered his own observations regarding "contextual factors" that he claims "are missing or incomplete from the OIG report." His comments appear to reflect a misunderstanding of the OIG's analysis and findings, as well as the purpose of the OIG's investigation.

First, the VISN 1 director states that, "as it relates to the unfortunate delay in locating Mr. White, the issue of who 'owns' the stairwells is a distinction without a difference." To the contrary, a determination that the stairwells were not leased space and remained VA property is central to an examination of VA's responsibilities at the time of Mr. White's disappearance. If VA had been conducting regular police patrols of Building 5 and cleaning the emergency exit stairwells at the time Mr. White was reported missing, his body likely would have been located earlier. Whether access would have been granted on request is immaterial. The VISN 1 director further states that the OIG has implied a "lack of clarity on who owned the stairwell somehow prevented searching," which is simply false. The OIG did not assert that lack of clarity around stairwell ownership "prevented searching." Instead, as noted, the ownership of the exit stairwells was relevant to the OIG's analysis of VA's maintenance and law enforcement obligations with respect to Building 5.

Second, the VISN 1 director contends that "[t]he general public would benefit from a more thorough understanding" of the actions taken by the Caritas Communities Inc. (Caritas) staff in locating Mr. White. The VISN 1 director appears to confuse the purpose of the OIG's investigation, which was to assess VA's role in the failure to locate Mr. White. Issues related to the response of Caritas staff were included in the district attorney's investigation, and any questions related to this issue should be directed to the district attorney's office. Moreover, any failure to search for Mr. White by Caritas does not alter the OIG's findings or excuse VA's own shortcomings that VA leaders have agreed to address in their action plans.

Third, the VISN 1 director's statement that "the OIG cites in their report the need for VA Police to have a presence in all space on VA campuses" mischaracterizes the report's discussion of VA's public safety obligations. As explained in the report, VA police are responsible for patrol

services and law enforcement duties on VA property. In order to fulfill this requirement, and at the same time be “sensitive to the need to respect the privacy of the residents of the [enhanced-use lease], by not frequently walking through their living space,” as the VISN 1 director suggests, VA police should be aware of exactly what space on VA campuses constitutes VA property and what areas are leased. The OIG report makes several recommendations to ensure that key medical center staff have a clear understanding of the actual boundaries of leased space, as well as VA’s responsibilities under the lease, which in this instance specifically requires VA police to provide patrol services.

In short, as reflected by all three of the VA entities’ concurrences, the OIG’s report contains a complete and accurate discussion of VA’s role in the failure to locate Mr. White, and analysis of applicable VA policies and procedures.

## OIG Contact and Staff Acknowledgments

---

<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
<b>Primary Contributors</b>	Leanne Watkins, Senior Administrative Investigator Michael Dinet, Investigative Attorney Silvia Gonzalez Roman, Supervisory Investigative Attorney Rebecca Kline Dubill, Director of Quality Assurance Jamie Wright, Senior Management & Program Analyst
<b>Other Acknowledgments</b>	Domingo Alvarez, Senior Administrative Investigator Sabrina Gregory, Forensic Auditor Emily Marcus, Senior Management & Program Analyst Jamie Mitchell, Deputy Assistant Inspector General Laura Owen, Senior Management & Program Analyst Ashley Shingler, Senior Management & Program Analyst

---

## Report Distribution

### VA Distribution

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel

### Non-VA Distribution

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans Affairs,  
and Related Agencies  
House Committee on Oversight and Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs,  
and Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget  
U.S. Senate: Edward Markey and Elizabeth Warren  
U.S. House of Representatives: Jake Auchincloss, Katherine Clark, William Keating,  
Stephen F. Lynch, Jim McGovern, Seth Moulton, Richard E. Neal, Ayanna Pressley, and  
Lori Trahan