Month-long missing Massachusetts man found dead in stairwell yards from his room at VA campus

The OIG's administrative investigation examined the circumstances surrounding the death of a veteran on the Edith Nourse Rogers Memorial Veterans Hospital campus in Bedford, Massachusetts (the medical center).

Mr. Timothy White was a resident of the Bedford Veterans Quarters (BVQ), an independent living facility operated by Caritas Communities, Inc. (Caritas), in space leased to it through VA's enhanced-use lease program. A month after Mr. White was reported missing, his body was found in the emergency exit stairwell of the building that houses the BVQ. This stairwell down the hall from his room was VA property and not leased to Caritas.

The VA police department's failure to locate Mr. White resulted in part from the police and others at VA not considering the veteran an at-risk missing patient, which would have required a stairwell search. The Veterans Health Administration and the Office of Security and Law Enforcement lacked clear guidance regarding the obligations of VA police to search for nonpatients reported missing on VA property.

VA police also did not discover Mr. White in the stairwell because of an improper order by the then police chief to cease patrols of the building in which Mr. White was found. The OIG found that the VA police chief exceeded his authority as both VA policy and the lease required VA police to patrol VA property.

Lastly, because medical center staff mistakenly believed the

emergency exit stairwells were not VA space, they did not clean them. The confusion among medical center leaders and staff regarding the lease scope and VA's obligations stemmed from a lack of clear guidance from the Office of Asset and Enterprise Management. Routine police patrols and stairwell cleanings likely would have led to Mr. White being found earlier.

VA concurred with the OIG's seven recommendations to improve policies and procedures.