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

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Environmental Suicide Hazards at the VA Boston Healthcare System in Brockton, Massachusetts


| Preliminary Result Advisory Memorandum | 25-03934-33 | December 18, 2025 |
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The Office of Inspector General (OIG) has released this issue statement to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation.

December 11, 2025

**PRELIMINARY RESULT ADVISORY MEMORANDUM**

**TO:** John Figueroa, Senior Advisor performing the delegable duties of VA Under Secretary for Health, Veterans Health Administration (10)

**FROM:** Dr. Julie Kroviak, Principal Deputy Assistant Inspector General, in the role of Acting Assistant Inspector General, Office of Healthcare Inspections (54), VA Office of Inspector General

**SUBJECT:** Environmental Suicide Hazards at the VA Boston Healthcare System in Brockton, Massachusetts

The VA Office of Inspector General (OIG) is issuing this preliminary result advisory memorandum to report a serious patient safety issue involving suicide hazards—including anchor points (objects that could be used to attach a cord or other material for self-harm)—observed at the VA Boston Healthcare System (facility) in Brockton, Massachusetts.[1] The suicide hazards were observed during an on-site inspection of the facility's inpatient mental health units conducted on November 18 and 19, 2025. Given the seriousness of the issue and similar concerns identified at other facilities, the OIG is broadly disseminating these preliminary findings to ensure that other Veterans Health Administration (VHA) facilities are aware of this vulnerability and can proactively address similar suicide risks across the enterprise.[2]

VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, requires facility staff to assess for suicide hazards twice annually on inpatient mental

[1] "Reducing Harm from Ligatures in Mental Health Wards and Wards for People with a Learning Disability," National Mental Health and Learning Disability Nurse Directors Forum, November 21, 2023, https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance. accessed December 3, 2025.

[2] VA OIG, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, September 26, 2024; VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 24-01859-62, March 5, 2025; VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, Report No. 24-01862-151, June 26, 2025; VA OIG, *Mental Health Inspection of the VA Salem Healthcare System in Virginia*, Report No. 24-01861-144, June 26, 2025. "Hazards on Mental Health Units: August 2025 Patient Safety Call," National Center for Patient Safety, accessed December 1, 2025, https://dvagov.sharepoint.com/:p:/r/sites/vhancps/_layouts/15/Doc.aspx?sourcedoc=%7B5E463666-BE0F-4CA2-9BFF-173C38E8B087%7D&file=Hazards%20on%20Mental%20Health%20Units%20August%202025%20Patient%20Safety%20call.pptx&action=edit&mobileredirect=true. (This site is not publicly accessible.)

health units.[3] The Mental Health Environment of Care Checklist—the safety inspection tool mandated by VHA Directive 1167—requires that certain features be in place to mitigate suicide risk. Features include, but are not limited to,

- toilets mounted to the floor and wall with integrated seats,
- enclosed plumbing,
- sink faucets and handles that are rounded or tapered,
- cabinets without anchor points,
- secured storage for medical equipment, and
- cords too short to be used for self-harm.[4]

At the time of the inspection, the facility had a total of 111 authorized inpatient mental health beds across four units. During a physical inspection of the units, the OIG team found several objects that could be used as anchor points for hanging, and other high-risk items, posing serious risk of death by suicide. These objects included

- toilets not flush-mounted to the floor and wall, with removeable seats that created anchor points;
- exposed plumbing;
- sink faucets and handles that are not tapered or rounded;
- cabinet door handles with anchor points; and
- unsecured medical equipment and cords.[5]

Preliminary findings were communicated November 18 through 20, 2025, to the interim Facility Director, the Chief of Mental Health, and inpatient unit staff. In response, facility leaders removed some hazardous items from patient care areas and implemented interim risk mitigation measures for the remaining hazards. These measures included 15-minute patient safety checks, staff education on specific environmental hazards, and continuous observation in common areas. At the OIG's request, facility leaders conducted a risk assessment of identified safety concerns to determine the level of risk and developed corresponding long-term corrective actions.

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[3] VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024.

[4] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, November 18, 2025, accessed December 10, 2025, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Inpatient.aspx. (This site is not publicly accessible.); VHA Directive 1167.

[5] "Mental Health Environment of Care Checklist," November 18, 2025.

The OIG's oversight of the facility remains ongoing, and a comprehensive analysis of these findings will be included in the final inspection report.

JULIE KROVIAK, MD
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# OIG Contact and Staff Acknowledgments

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