

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.

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Mr. Joe Jimenez
210 West White Avenue
San Antonio, TX 78214

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-12-1933 and Letter from the Honorable Secretary of Veterans Affairs, Secretary Eric K. Shinseki Regarding the Agency's Investigative Report Dated September 18, 2012

Dear Ms. Lerner,

I am in receipt of a letter addressed to you, dated October 12, 2012, from The Honorable Secretary of Veterans Affairs, Eric K. Shinseki regarding the allegations of misconduct involving the Department of Veterans Affairs (VA) South Texas Veterans Health Care System, Audie Murphy Memorial VA Hospital, in San Antonio, Texas. Additionally, I have a copy of the agency's investigative report (AIR) addressed to the Office of Special Counsel (OSC) regarding the allegations I (whistleblower) made involving misconduct that constituted a violation of law, rule or regulation, gross management or a substantial and specific danger to public health.

I have reviewed the agency's investigative report and concur with some of their findings, conclusions, and recommendations; however, I have points of disagreements in several areas of the Report. Pursuant to 5 U.S.C. 1213(e)(1), I am submitting my comments regarding the Report. Furthermore, I am attaching a copy of a consent form so that my comments can become part of a public file, maintained by OSC pursuant to 5 U.S.C. 1219(a)(1). My comments that shall be provided to the President and the congressional committees with jurisdiction over the agency.

Thank you for the opportunity to provide my comments to this issue.

Respectfully submitted,

/S/ Joe Jimenez

Joe Jimenez, Complainant

Cc: Jennifer B. Pennington, OSC
Enclosure

JOE JIMENEZ, COMPLAINANT

Comments to the Report to the Office of Special Counsel

OSC File Number DI-12-0927 and DI-12-1933

Date: December 13, 2012

Complainant's Comments

Letter from Secretary of Veteran Affairs

Secretary Eric K. Shinseki wrote, "The investigation did find one violation of rules related to failure to report a dosing error". Although the Agency Investigative Report (AIR) was primarily limited to issues under Nuclear Regulatory Commission (NRC) regulatory purview and best health physics practices, it is imperative that the Secretary acknowledge that several other violations of rules and federal statues occurred.

President Barack Obama signed the Whistleblower Protection Enhancement Act, which expands the rights of federal workers who report fraud, misconduct or other illegal actions. Under the new law, which passed unanimously in the Senate, the scope of protected employee disclosures has been expanded as well as the penalties for agencies that violate whistle-blower protections.

The Act makes it easier to punish supervisors who retaliate against workers. No worker should be retaliated against when they report the fraud, misconduct or wrongdoings of their employer--whether in the private sector or the government.

As per WPA, the Secretary is required to consider punishment of supervisors, at the Department of Veterans Affairs (VA) South Texas Veterans Health Care System, Audie L. Murphy Memorial VA Hospital, in San Antonio, Texas, who knowingly and willingly retaliated against the two whistleblowers listed in the AIR.

The Secretary should take the leadership role by demonstrating to the agency management that the Department of Veterans Affairs (VA) has a zero tolerance of reprisal of whistleblowers.

Executive Summary

Allegation # 1—Recommendation (Pg. 2)

According to the AIR, “the facility should continue with efforts for increase communication between nuclear medicine service and the Radiation Safety Office. The facility should continue with efforts to effectively communicate with all staff and finalize any needed changes to the procedures manual”.

Response—Communication between nuclear medicine service and the Radiation Safety Office was almost nonexistent. However, when the nuclear technologists and Mr. Chea Kim, Chief Nuclear Medicine Technologist met for a staff meeting, the suggestions made were chastised and belittled publicly by Kim. Moreover, in some cases, management because of their suggestions targeted technologists.

Pursuant to 10 CFR 20.11(a) requires a permittee to develop, document, and implement a radiation protection program commensurate with the scope and extent of permitted activities and sufficient to ensure compliance with 10 CFR 20.

It is my belief that Dr. Daniel Duffy, M.D., Physician, Chief, Nuclear Medicine Service, failed to comply with 10 CFR 20.11(a). Upon assuming the responsibilities as the Chief, Nuclear Medicine Service, one of his first primary duties was to ascertain that a radiation protection program was in place. The unavailability of a radiation protection program manual contributed to the number of nuclear spills that occurred at South Texas Veterans Health Care System, Audie L. Murphy Memorial VA Hospital.

Although change is a constant process, it is imperative that employees are informed of the changes and provided a copy of the manual to comply as per 10 CFR

20.11(a). Unfortunately, management failed to implement changes effectively resulting in confusion amongst the staff technologists.

Allegation # 2—Findings (Pg. 2)

According to the IR, “A contamination event occurred on September 20, 2011, which resulted in extensive clean up efforts. Two staff involved in the clean-up had higher dose results for that time period, though the does results were not clearly related to the clean-up”. “The lack of a recently updated imaging procedure does not specifically impact spill procedures, or the possibility of a spill for an individual patient procedure”.

Cause and effect (also written as cause-effect or cause/effect or cause and consequence) refers to the philosophical concept of causality, in which an action or event will produce a certain response to the action in the form of another event. The significant term used in the above paragraph, is contamination. The medical definition of contamination:

1. The soiling or making inferior by contact or mixture.
2. The deposition of radioactive material in any place where it is not desired.

To prevent the spread of contamination, one must not panic, but stop what they are doing. In case of contamination, the follow measures should be taken:

1. Presume the area is contaminated.
2. Inform others of the situation and restrict access to the area.
3. Survey for personal contamination.
4. Remove any contaminated clothing.
5. Address contamination on skin.

6. Activity of the spills greater than 10 μCi , special care should be implemented.
7. Spills outside the immediate work area, special care should be implemented.
8. If the spill covers a large area or volume, special care should be implemented.

Use dosimeter or the proper protection equipment: gloves, laboratory coat, eye protection, booties, before attempting spill clean up. Survey the contaminated area. Mark the perimeter of the spill and any isolated spots. Clean the spill area by wiping the contamination with dampened paper towels working from the perimeter towards the center of the spill.

Respectfully, management panicked. Under the orders from Dr. Duffy and Mr. Chea, I was ordered to scrub the floors where the spill occurred in the hallway adjacent to the Nuclear Medicine Laboratory. The above recommendations of controlling a spill were not followed accordingly. What was alarming is that the general public (visitors) walking in the hallway adjacent to the Nuclear Medicine Service were exposed (shoes) to the spills. An example, a nuclear medicine physician carried radiation material attached to the soles of his shoes to the reading room of the nuclear medicine area. The area was not blocked off immediately and the general public walked in the area of exposure, which leans itself to violation of the principles of ALARA, acronym for "As Low as Reasonably Achievable. "It means making every reasonable effort to maintain exposures to ionizing radiation as far below the dose limits as practical. Be consistent with the purpose for which the licensed activity is undertaken, taking into account the state of technology, the economics of improvements in relation to state of technology, the economics of improvements in relation to benefits to the public health and safety,

and other societal and socioeconomic considerations. These means are in relation to utilization of nuclear energy and licensed materials in the public interest.

Pursuant to 10 CFR 35.27(a) requires permittee to instruct supervised individuals (i.e., nuclear medical technologist working under the direction of a physician user), in the permittee written radiation protection procedures. In addition, this NRC regulation requires supervised individuals to follow instructions of the physician-authorized user. When Dr. Duffy ordered the above mention spill clean up, he violated 10 CRR 35.27 and the principles of ALARA.

When contamination does occur, the area of contamination should be limited or contained by isolation. Verbal notifications, warning signs, and labels should be used to alert others to the presence of the hazard until subsequent cleanup activities are completed. Decontamination is the responsibility of the individual causing the spill, but call for assistance if deemed necessary or if you are inexperienced in decontamination efforts. Radiation Safety (RS) staff is available to provide assistance in decontamination, if necessary.

Again, the unavailability of a radiation protection program manual contributed to panic that occurred in the clean-up of the spill at South Texas Veterans Health Care System, Audie L. Murphy memorial VA Hospital.

Allegation # 3—Findings (Pg. 4)

According to IR, "In January 2011, a patient was injected with a cardiac stress dosage that was around 30 millicuries instead of the prescribed dosage of 10 millicuries for a rest-phase cardiac test". The nuclear technologist who made the error was Mr.

Chea Kim, Chief Nuclear Technologist and Supervisor, Nuclear Medicine, at South Texas Veterans Health Care System, Audie L. Murphy memorial VA Hospital.

The Secretary acknowledges, "The investigation did find one violation of rules related to failure to report a dosing error". However, other issues need to be acknowledged.

1. Dr. Daniel Duffy, Dr. Clavin Lueshen, Chief of Imaging Service, Dr. Julianne Flynn, M.D., Chief of Staff, Mr. Wade Vlosich, Chair, Radiation Safety Committee, and Ms. Marie Weldon, Director at South Texas Veterans Health Care System, Audie L. Murphy memorial VA Hospital should have requested that a root-cause analysis be conducted regarding the error of dosage. They did not. Rather, they covered up the incident by failing to report the over dosage to the proper authorities. The nuclear medicine technologists were aware of the over dosage and the message that was portrayed by management is that they will not hold themselves accountable. Rather, non-management nuclear technologists will be held at a different level of accountability.
2. Had the over dose been reported as per 10 Code of federal regulations (CFR) 35.3045, there is a significant positive correlation that the lack of communication that existed, according to the IR, would have been resolved and prevented spills that occurred in September 2011. Additionally, the IR does not report the numerous spills that have occurred in nuclear medicine. I agree with the IR in that nuclear spills will occur by virtue of human error.

However, to terminate me for an error in September 2011 that was more related to the equipment than the human error is inappropriate.

3. Ms. Marie Weldon, Director, and Mr. Peter Vargas, Human Resource Specialist, at South Texas Veterans Health Care System, Audie L. Murphy memorial VA Hospital were informed of the over dose. Although I requested protection as a whistleblower from Ms. Weldon and Mr. Vargas, on February 2012, she terminated me from government service, after 32 years of honorable service with the VA.

In conclusion, it should be obvious to the Secretary, the President and the congressional committees with jurisdiction over the agency, which the disclosure involves, based on the IR and my comments, that there are numerous leadership and management problems that exist at South Texas Veterans Health Care System, Audie L. Murphy memorial VA Hospital. What is equally obvious is that our Veterans are not receiving the level of patient care they have earned.

Our military personnel and veterans have seen how President Obama has put them first in safety and also pushed for enhanced benefits for veterans. Taken together, military leadership and a true focus on the needs of veterans, it has become clear to many in and out of the service that President Obama has earned their trust.

The Secretary has an obligation to hold leadership, from Ms. Marie Weldon, Director, up to the Under Secretary of VHA, Dr. Robert Petzel accountable for what has transpired in this violation of rules related to failure to report a dosing error. Radiation spills and dosage errors reflects a substantial and specific danger to the public health and Veterans specifically.

Sincerely,

/S/ Joe Jimenez

Joe Jimenez

Cc: Jennifer B. Pennington, OSC

Enclosure