

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

June 18, 2013

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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-12-0927 AND DI-12-1933 Letter from Gary E. Williams  
Dated March 25, 2013

Dear Ms. Lerner,

I am in receipt of a letter addressed to you, dated April 10, 2013, from Walter A. Hall, Assistant General Counsel, regarding the above reference OSC Files.

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.

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

**JOE JIMENEZ, COMPLAINANT**

**Comments to the Report to the Office of Special Counsel**

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

**Date: June 18, 2013**

## **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.

**AR Response to Item # 2—Recommendation (Pg. 2 of 6)**

According to the Agency's Response (AR), "The Nuclear Medicine Service is not specifically required by policy or regulation to have approval by either the RSC or RSO to initiate use of a clinical imaging protocol, especially a protocol that is in the current procedure manual, if such use does not change the radiation protection program".

**Jimenez Response to Item 2**—the agency's statement indicates that a *current* procedural manual, with the changes that were made, exist, it did not. A procedure entitled "Ling Aerosol Study (Tv-99-DTPA), dated January 25, 2003 was in the Nuclear Medicine Service procedure binder. 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 to update the manual to reflect current changes, they 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 (Mr. Eric Wittenbach) 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 placed. 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.

**AR Response to Item 3**—According to the AR, “A procedure entitled “Ling Aerosol Study (Tv-99-DTPA), dated January 25, 2003 was in the Nuclear Medicine Service procedure binder.” “Dr. Duffy signed the binder on June 2, 2011”.

**Jimenez Response to Item 3**—Pursuant to 10 CFR 20.11(a) requires a permittee (Mr. Eric Wittenbach) 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. No training regarding the use of procedures and suggested protocols from the manufacture of the Ultravent Radioaerosol Delivery System was provided.

**AR Response to Item 4**— According to the AR, Mr. Kim provided training to the technologist.

**Jimenez Response to Item 4**—Mr. Kim is being untruthful. He did not provided the level of training that is required. Statistically speaking, if he did provide training, why did the Service has so many spills? A contamination event occurred on September 20, 2011, which resulted in extensive cleanup 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  $\mu\text{Ci}$ , 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 cleanup. 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 cleanup, 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.

**AR Response to Item 5**—According to the AR, Mr. Kim provided verbal training to the technologist.

**Jimenez Response to Item 5**— Mr. Kim is being untruthful. He ignored the technologist and his leadership style was “It is my way, don’t question me”. Such leadership style is not training. Such styles lead to the numerous spills in Nuclear Medicine including a spill that both Dr. Duffy and Mr. Chea were directly involved.

**AR Response to Item 6**— According to the AR, “VA is not authorized to provide the root cause analysis report as it is protected 5705 quality assurance document”.

**Jimenez Response to Item 6**—According to 38 USC 5705,

(a)Records and documents created by the Department as part of a medical quality-assurance program (other than reports submitted pursuant to section 7311(g))<sup>[1]</sup>

of this title) are confidential and privileged and may not be disclosed to any person or entity except as provided in subsection (b) of this section.

(b)

(1) Subject to paragraph (2) of this subsection, a record or document described in subsection (a) of this section shall, upon request, be disclosed as follows:

(A) To a Federal agency or private organization, if such record or document is needed by such agency or organization to perform licensing or accreditation functions related to Department health-care facilities or to perform monitoring, required by statute, of Department health-care facilities.

(B) To a Federal executive agency or provider of health-care services, if such record or document is required by such agency or provider for participation by the Department in a health-care program with such agency or provider.

(C) To a criminal or civil law enforcement governmental agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or document be provided for a purpose authorized by law.

(D) To health-care personnel, to the extent necessary to meet a medical emergency affecting the health or safety of any individual.

"Whenever misdeeds take place in a Federal agency, there are employees who know that it has occurred, and who are outraged by it. What is needed is a means to assure them that they will not suffer if they help uncover and correct administrative abuses ... These conscientious civil servants deserve statutory protection ..." See 5 U.S.C. § 1213(h) (prohibiting the Special Counsel from disclosing the identity of a whistleblower

without the individual's consent unless disclosure becomes necessary due to an imminent danger to public health or safety or imminent violation of any criminal law); 5 U.S.C. App. § 7(b) (prohibiting IGs from disclosing the identity of a whistleblower without the whistleblower's consent unless an IG determines such disclosure is unavoidable during the course of an investigation).

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 had 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 technologist 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 technologist 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.

Therefore, I believe that OSC has the right to receive a copy of the root cause analysis.

**AR Response to Item 7—** According to the AR, “The ALARMA concept as a regulatory perspective, is applicable to radiation workers and members of the public but not to patients.”

**Jimenez Response to Item 7**—ALARA is an acronym meaning **As Low As Reasonably Achievable**. It is a requirement in the law, meaning all facilities possessing radioactive materials licenses must have a formal ALARA program. It may be defined as a professional standard of excellence, and is practiced by keeping all doses, releases, contamination and other risks as low as reasonably achievable.

### **Maximum Permissible Exposure**

Exposure standards have been established by the NRC and set at a level where apparent injury due to ionizing radiation during a normal lifetime is unlikely. This limit is called the "maximum permissible exposure". However, personnel should not completely disregard exposures at or below these limits. It is the responsibility of each individual to keep his/her exposure to all radiation as low as is reasonable, and to avoid all exposures to radiation when such exposures are unnecessary.

The exposure limit for whole body exposures is lower than that for a single organ because all organs and tissues are exposed in a whole body exposure, while only a single organ is involved in the single organ exposure limits. The risk to the organ is incorporated in the exposure calculations, which must be done if organs or tissues are exposed. Maximum permissible exposure limits to external radiation for adult and minor radiation workers are given in the table below.

New dose quantities were incorporated in the 10 CFR 20 law that took effect on 1/1/94. Notice that each of the following quantities are types of dose equivalents. The following definitions describe the new quantities. (Note: the types of doses are quantities; the units used for these quantities are the rem or the Sievert.)

## **Exposure Limits for the General Public**

Visitors to a radiation laboratory who are not classified as radiation workers by their employers, laboratory workers who are not trained in radiation safety, custodial staff, and any other non-radiation workers are all members of the general public under the law. They must not receive a radiation dose in excess of either:

- 1. Two mrem in any one hour.**
- 2. 100 mrem in any one year.**

According to Health Physics Society, "Regarding the concern of a trend to do away with the As Low As Reasonably Achievable (ALARA) concept for patient protection, I can tell you that this does not appear to be the case. There have been a number of topics in the last few years to indicate that ALARA for patients is alive and well. The two most noted are the Food and Drug Administration (FDA) recommendations regarding prolonged fluoroscopy and concerns regarding excessive exposure to pediatric patients from CT scans. Both issues have received attention in the media and by professional organizations and societies. Efforts continue to optimize patient studies while using only the radiation necessary to properly perform the procedure. There are cases, however, such as the one that you raised, where it may appear that ALARA is being reconsidered. In reality, some regulations may be relaxed due to the very low risk to the patient and others. Another example of this situation is the use of bone densitometers, which are fixed radiographic x-ray units. However, the patient dose and scatter dose are considerably lower than for a conventional radiographic x-ray room. Remember that the goal of ALARA is to keep exposures as low as reasonably achievable, while taking

social and economic factors into account.

(<http://www.hps.org/publicinformation/ate/q3101.html>)

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