No. _____

IN THE
Supreme Court of the United States

FELISA TUNAC, on behalf of herself
and as the Personal Representative
of the Estate of Randy Tunac
(Veteran), Deceased,
Petitioner,

v.

UNITED STATES OF AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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Pro se

QUESTIONS PRESENTED FOR REVIEW

1) Whether the court below erroneously held that its jurisdiction was limited by the Veterans' Judicial Review Act to negligence claims against Department of Veterans Affairs healthcare employees?

PARTIES TO THE PROCEEDING

All parties are listed in the caption.

RULE 29.6 STATEMENT

The Petitioner is not a nongovernmental corporation and does not have a parent corporation or shares held by a publicly traded company.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit, filed July 30, 2018, is reported at *Tunac v. United States*, 897 F.3d 1197. The opinion is reprinted in the Appendix hereto, pp. 1-20.

The memorandum order of the United States District Court for the District of Arizona dated December 5, 2016 is reprinted in the Appendix hereto, at pp. 21-36.

JURISDICTION

On April 8, 2016, Petitioner Felisa Tunac brought suit against Respondent United States of America and other Defendants in the United States District Court for the District of Arizona, alleging that Respondent and others had negligently caused the death of Petitioner's husband, medically-retired United States Navy veteran, Randy Tunac. On June 22, 2016, Petitioner filed an amended complaint, voluntarily dismissing the other Defendants.

On December 5, 2016, the Honorable Roslyn O. Silver, Senior United States District Judge for the United States District Court for the District of Arizona, filed an order granting in part and denying in part Respondent's motion to dismiss. On January 4, 2017, Petitioner appealed the dismissal of her complaint to the United States Court of Appeals for the Ninth Circuit.

On July 30, 2018, the Ninth Circuit issued an opinion affirming the District Court's dismissal.

Jurisdiction is invoked under 28 U.S.C. §1254(1) for this Court to review the Judgment of the Ninth Circuit Court of Appeals.

CONSTITUTIONAL PROVISIONS, STATUTES AND POLICIES AT ISSUE

28 U.S.C. § 1346(b)

(b)

(1) Subject to the provisions of chapter 171 of this title, the district courts, together with the United States District Court for the District of the Canal Zone and the District Court of the Virgin Islands, shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages, accruing on and after January 1, 1945, for injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred.

28 U.S.C. § 2671

As used in this chapter and sections 1346(b) and 2401(b) of this title, the term "Federal agency" includes the executive departments, the judicial and

legislative branches, the military departments, independent establishments of the United States, and corporations primarily acting as instrumentalities or agencies of the United States, but does not include any contractor with the United States.

"Employee of the government" includes (1) officers or employees of any federal agency, members of the military or naval forces of the United States, members of the National Guard while engaged in training or duty under section 115, 316, 502, 503, 504, or 505 of title 32, and persons acting on behalf of a federal agency in an official capacity, temporarily or permanently in the service of the United States, whether with or without compensation, and (2) any officer or employee of a Federal public defender organization, except when such officer or employee performs professional services in the course of providing representation under section 3006A of title 18.

"Acting within the scope of his office or employment", in the case of a member of the military or naval forces of the United States or a member of the National Guard as defined in section 101(3) of title 32, means acting in line of duty.

38 U.S.C. § 511

(a) The Secretary shall decide all questions of law and fact necessary to a decision by the Secretary under a law that affects the provision of benefits by the Secretary to veterans or the dependents or

survivors of veterans. Subject to subsection (b), the decision of the Secretary as to any such question shall be final and conclusive and may not be reviewed by any other official or by any court, whether by an action in the nature of mandamus or otherwise.

(b) The second sentence of subsection (a) does not apply to—

(1) matters subject to section 502 of this title;

(2) matters covered by sections 1975 and 1984 of this title;

(3) matters arising under chapter 37 of this title; and

(4) matters covered by chapter 72 of this title.

STATEMENT OF THE CASE

Petitioner Felisa Tunac is the surviving spouse of Randy Tunac, a medically-retired United States veteran (Navy), who continued to receive treatment from the VA after his retirement.

In 1995, Mr. Tunac began a six-month deployment with the U.S. Navy in the Mediterranean. Before Mr. Tunac completed his deployment, he began to experience serious medical issues and, as a result, he was evacuated back to Norfolk, Virginia and then to Portsmouth Naval Base for testing. Mr. Tunac was diagnosed with lupus nephritis – an inflammation of the kidneys caused by systemic lupus erythematous, an autoimmune disease. It was explained to him in simple terms that, "when the kidneys are inflamed, they cannot function properly, and, if the condition is not controlled, it can lead to kidney failure," or words to that effect. After his diagnosis, Mr. Tunac began undergoing chemotherapy treatment. Two years after his initial diagnosis, Mr. Tunac finally recovered. However, in approximately September 1997, Mr. Tunac's lupus relapsed, and he was then medically retired from the military. Mr. Tunac received continual care from the VA during this entire time.

After medical retirement, Mr. Tunac attended law school, was admitted to the Arizona State Bar, and began practicing law. Shortly after beginning his practice in 2001, Mr. Tunac suffered a heart attack. Although Mr. Tunac continued treatment for his lupus with the VA and, specifically, at the Carl T.

Hayden VA Medical Center located in Phoenix, Arizona ("the Phoenix VA"), he was treated for his heart condition by a non-VA/private cardiologist, David Wilcoxson, M.D.

In mid-2009, Mr. Tunac saw Dr. Wilcoxson and had bloodwork done. Mr. Tunac's bloodwork indicated that his kidney function was failing and he needed to be seen right away because his condition was at the point where it could soon become a life or death situation. Dr. Wilcoxson ordered Mr. Tunac to make an appointment immediately at the VA Medical Center. Mr. Tunac promptly contacted the Phoenix VA and expressed the emergency need(s). Despite the urgency of Mr. Tunac's condition, the earliest he could get an appointment at the Phoenix VA was November 2009, months after his diagnosis and Dr. Wilcoxson's order.

As Dr. Wilcoxson predicted, while Mr. Tunac was waiting to receive care at the Phoenix VA, his kidneys began to fail. Mr. Tunac was finally seen in the Phoenix VA on December 2, 2009, where his kidney was biopsied. The VA's results of the biopsy confirmed that Mr. Tunac had reached end-stage kidney disease, and he was scheduled to begin undergoing dialysis for this condition. Again, the Phoenix VA could not schedule Mr. Tunac immediately and set his next appointment for December 30, 2009 – nearly a month later. The Phoenix VA did not schedule Mr. Tunac to commence treatment of his active lupus nephritis until January 14, 2010.

While awaiting the appointments, Mr. Tunac's condition worsened. On December 23, 2009, he collapsed at work and was rushed by ambulance to St. Joseph's Hospital in Phoenix, Arizona. He was pronounced brain dead upon arrival. Mr. Tunac had suffered respiratory failure due to congestive heart failure, coronary artery disease, and anoxic encephalopathy – all of which result from renal failure (end-stage kidney disease). Mr. Tunac passed on December 27, 2009, at the age of 47, leaving behind his wife and two sons, Joshua and Bryan.

The Phoenix VA and its employees failed to timely schedule or address Mr. Tunac's dire medical condition with the attention it required. No attempt was made to perform any necessary triage with regard to Mr. Tunac or to accelerate the treatment that Mr. Tunac desperately needed. The Phoenix VA and its employees were, however, well aware of the gravity of Mr. Tunac's medical condition as the VA, itself, wrote to Mr. Tunac notifying him that his "active lupus nephritis" was of a "serious nature" and required immediate treatment or would end in "end stage kidney disease and even death."

Mr. Tunac's premature death was entirely avoidable if he was to have received timely treatment from the VA and its employees at the Phoenix VA.

At the time that Mr. Tunac passed, Petitioner had no knowledge (and no reason to investigate) the timing of appointments within the Phoenix VA. Petitioner believed that the timing of appointments was ordinary and customary, as she had routinely dealt with the Phoenix VA and its scheduling delays. However, in or about May 2014, Petitioner learned

for the first time of the widespread, systemic issues of delayed patient care within the VA and at the Phoenix VA, following media reports. Media reports alerted Petitioner that the Phoenix VA and its employees had engaged in "gross mismanagement" and "unacceptable wait times" that were contributing to otherwise preventable veteran deaths. ER 3 at p. 21, ¶40.

As a result of this news, Petitioner investigated to learn that an Internal Audit (dated June 9, 2014) conducted by the Office of the Inspector General ("OIG") of the VA confirmed how veterans were left waiting or never received necessary care; the Phoenix VA and its employees used "unofficial" lists and inappropriate practices to make waiting times appear more favorable; and, multiple veterans died as a result. *Id.* at ¶41. By August 26, 2014, the OIG issued its "Full Report," concluding there was "unacceptable and troubling" negligence in terms of follow-up, care coordination, quality and continuity of care. *Id.* at ¶42.

Within two (2) years of learning of her cause of action, Petitioner submitted her Notice of Claim and filed the pre-requisite Administrative Claim for this lawsuit. When her claim was denied, Petitioner timely filed a lawsuit in the district court.

The Claims

Petitioner's claims against the Respondent are two-fold. First, Petitioner alleged that the Phoenix VA was responsible for Mr. Tunac's wrongful death by failing in follow-up, quality and continuity of care with regard to his kidney condition. Second, she

alleged that the Phoenix VA committed negligence/medical malpractice by failing to provide Mr. Tunac with timely, quality care. Petitioner alleged that the Phoenix VA and its employees owed a duty to Mr. Tunac to provide him with timely, quality healthcare; the VA and its employees breached their duties by failing to provide adequate follow-up care and treatment, failing to schedule immediate (or timely) treatment, and failing to schedule immediate dialysis after the results of a significant/horrific kidney biopsy in December 2009. These failures contributed to the untimely death of Mr. Tunac and were the proximate cause of damages.

However, Petitioner did not know (and did not have any reason to know or to investigate) that the timing of veterans' appointments within the Phoenix VA were anything but normal. Petitioner did not understand that the Phoenix VA was mismanaging patient care, including making patients wait unacceptable time periods. She believed the delays were normal. Petitioner did not (and had no reason to) know that the Phoenix VA manipulated data, lied about wait times, and caused veterans' deaths.

The District Court Proceedings

The Respondent immediately moved for dismissal of Petitioner's claims, arguing both that the district court lacked subject matter jurisdiction (suggesting that the claims were a denial of veterans benefits and limited to jurisdiction in the United States Court of Appeals for Veterans Claims ("Veterans Court") only) and that the claims were untimely. The district court disagreed that Petitioner's claims were barred by 38 U.S.C. §511 as

claims for veterans benefits and found, more appropriately, that the claims arose as medical malpractice claims under the FTCA. Accordingly, the district court held that it had jurisdiction to hear the claims for medical malpractice – even when the malpractice was simply "based on delays in appointments."

On the other hand, the District Court determined that Petitioner's claims were untimely because they had accrued "as of December 2009." The court concluded that Petitioner either "knew or should have known as of December 2009 that the injury had been caused by the VA's delays." The District Court blamed Petitioner for not investigating her potential claims in 2010 after receiving a letter from the Phoenix VA expressing that Mr. Tunac missed a treatment appointment. Yet, the court disregarded Petitioner's pleading that she did not know (and had no reason to know) that the Phoenix VA had intentionally misled the public (including her) that its wait times were *normal* and that it manipulated data for the public, covering up wait times while veterans died. The District Court ignored the fact that the Phoenix VA itself was falsifying patient records/wait lists so that that public (like Petitioner) did not know that its scheduling practices were abnormal. In doing so, the District Court disregarded the August 26, 2014 OIG "Full Report" that was cited and incorporated into the First Amended Complaint by reference.

The Appellate Court Proceedings

On January 4, 2017, Petitioner appealed the dismissal of her complaint to the United States Court

of Appeals for the Ninth Circuit. On July 30, 2018, the Ninth Circuit issued a published opinion affirming the District Court's dismissal.

The Court of Appeals accepted this case in order to decide whether it would "have jurisdiction over a claim alleging that a medical center operated by the Department of Veterans Affairs (VA) caused [Mr.] Tunac's death by delaying urgently needed medical treatment." Appendix at p. 3. While the Court concluded that it had jurisdiction under the Federal Tort Claims Act (FTCA), 28 U.S.C. § 1346 to hear allegations of "negligence by VA healthcare employees (defined as medical professionals and related support staff listed in 38 U.S.C. §7316(a)(2))," it found that "negligence in VA operations" must proceed under the Veteran's Judicial Review Act (VJRA). *Id.*

REASONS WHY CERTIORARI SHOULD BE GRANTED

I.

Review Is Warranted To Provide The Circuit Courts With Guidance On The Intersection Between The Jurisdiction Of The Veterans Court And The Circuit Courts.

Both the District Court and the Court of Appeals have exemplified the need for a bright-line rule to guide Veterans in filing claims in the proper forum. This Court should set that rule.

Enacted in 1988, the Veterans' Judicial Review Act ("VJRA") established the United States Court of Appeals for Veterans Claims ("Veterans Court"), giving exclusive jurisdiction to the Veterans Court to hear "questions of law and fact necessary to a decision...that affects the provision of [veterans] benefits." 38 U.S.C. § 511(a). The VJRA further gave exclusive appellate jurisdiction to the Federal Circuit over Veterans Court decisions.

Since the enactment of the VJRA, district courts have struggled to determine jurisdiction over claims involving allegations of medical malpractice committed during the provision of benefits covered by the VJRA. This is due to the lack of any clear direction regarding the extension of the Veterans Court's exclusive jurisdiction to these claims and the resultant conflict between the VJRA and the Federal Tort Claims Act ("FTCA"). As stated by Honorable Roslyn O. Silver, Senior United States District Judge, in this case:

> In light of existing case law, there does not appear to be an entirely coherent way of applying § 511 to claims of medical malpractice. Rather than a bright-line distinction between situations where § 511 applies and where it does not, courts seem to make fact-dependent determinations of whether particular claims are best resolved by the administrative system available for veterans benefits decisions or by the tort system by way of FTCA actions.

The existing case law consists of a patchwork of "tests" and approaches that attempt to distinguish between claims subject to and outside of the VJRA. Where, however, benefits decisions necessarily implicate practice standards (and vice versa), a more pragmatic test is critical to the consistent application of jurisdictional limitations to ensure that veterans have a known and definite path to recourse for harms that they may have suffered at the hands of the providers entrusted with their care. Petitioner Tunac respectfully submits to this Court that the "entitlement" test rejected by the Ninth Circuit meets this requirement. *See, e.g.,* Appendix at p. 16, footnote 5.

The VJRA's jurisdictional grant extends only to decisions affecting the provision of veterans' benefits. Where a decision is made to either provide or deny a benefit – the veteran's entitlement – the VJRA provides exclusive jurisdiction to the Veterans Court. Anything beyond the entitlement questions, including issues concerning how the benefit or treatment was provided, requires a review of the applicable standard of care and falls within the confines of the FTCA. Thus, it seems entirely appropriate to create a bright-line rule in this Court that the VJRA would decide claims addressing veterans' entitlement to benefits; the District Courts would and should decide all other issues raised.

To exemplify the need for a bright and clear rule, this Court should note that claimants like the Petitioner here have been specifically (mis)guided where to file for relief. For example, when Petitioner filed her Administrative Claim, the VA classified it specifically as a claim under the FTCA and directed Petitioner to "file suit directly under the FTCA, 28

U.S.C. §§ 1346(b) and 2671-2680." Appendix at p. 39. The VA instructed Petitioner that its denial of her claim entitled her to "seek judicial relief in a Federal district court." *Id.* Clearly, the VA believed this matter to arise from the FTCA, and an uneducated or ill-equipped veteran would not know to challenge the VA's instruction(s) when given in this manner. Veterans/claimants should not be misguided to file District Court claims when and if the VJRA applies. Thus, any bright line rule of this Court should also include directing that the VA cannot (mis)guide a claimant and later argue lack of jurisdiction.

CONCLUSION

Based on the foregoing, Petitioner respectfully submits that this Petition for Writ of Certiorari should be granted. The Court may wish to consider summary reversal of the decision of the Ninth Circuit Court of Appeals.

Dated: October 26, 2018

Respectfully submitted,

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