THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes

WORKING GROUP

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

PROCEDURES REVIEW

The verbatim transcript of the Working Group Meeting of the Advisory Board on Radiation and Worker Health held in Cincinnati, Ohio, on March 13, 2008.

STEVEN RAY GREEN AND ASSOCIATES
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C O N T E N T S

March 13, 2008

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-- "uh-huh" represents an affirmative response, and "uh-uh" represents a negative response.

-- "*" denotes a spelling based on phonetics, without reference available.

-- (inaudible)/ (unintelligible) signifies speaker failure, usually failure to use a microphone.

-- “^” denotes telephonic failure.

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(By Group, in Alphabetical Order)

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P R O C E E D I N G S

MARCH 13, 2008

(9:30 a.m.)

OPENING REMARKS

DR. BRANCHE: Good morning. This is Dr. Christine Branche, and we're starting the worker group, worker Procedures meeting this morning from the Advisory Board on Radiation and Worker Health. And I'd like to start with the Board members announcing their names please.

DR. ZIEMER: Paul Ziemer, Board member.

MS. MUNN: Wanda Munn, Chair of this group.

MR. GRIFFON: Mark Griffon, Board member.

MR. GIBSON: Mike Gibson.

DR. BRANCHE: Are there any other Board members on the line?

(no response)

DR. BRANCHE: So we don't have a quorum so we can proceed. NIOSH staff with us in the room, please.

MR. ELLIOTT: This is Larry Elliott, Director of OCAS.

MR. HINNEFELD: Stu Hinnefeld, Technical Program Manager for OCAS.

MS. ADAMS: Nancy Adams, Office of the Director, NIOSH.

DR. BRANCHE: Christine Branche, Principal Associate Director and Designated Federal Official at NIOSH.

NIOSH staff on the phone please?

MS. BURGOS (by Telephone): Zaida Burgos.

DR. BRANCHE: ORAU staff in the room please.

MS. THOMAS: Elyse Thomas.

DR. BRANCHE: ORAU staff by phone.

(no response)

DR. BRANCHE: SC&A staff in the room.

DR. MAURO: John Mauro, SC&A.

MR. MARSCHKE: Steve Marschke.

DR. BRANCHE: SC&A staff by phone please?

MS. BEHLING (by Telephone): Kathy Behling.

DR. ANIGSTEIN (by Telephone): Bob Anigstein.

MR. LOOMIS (by Telephone): Don Loomis.

DR. BRANCHE: Other federal agencies' staff in the room please.

MS. HOWELL: This is Emily Howell with Health and Human Services.

DR. BRANCHE: Other federal agency staff by phone please.

MS. HOMOKI-TITUS (by Telephone): Liz Homoki-Titus with HHS.

MS. CHANG (by Telephone): Chia-Chia Chang with NIOSH.

MR. KOTSCH (by Telephone): Jeff Kotsch with Labor.

DR. BRANCHE: Are there any petitioners or their representatives who would like to introduce themselves on the phone?

(no response)

DR. BRANCHE: Any workers or their representatives on the phone please?

(no response)

DR. BRANCHE: Any members of Congress or their representatives on the phone, please?

(no response)

DR. BRANCHE: Anyone else who would like to mention their names?

(no response)

DR. BRANCHE: Before we get started I would like to ask those of you who are in the room please to mute your phones. And for those of you who are participating by phone if you would be so kind as to mute your phone when you are not speaking. If you do not have a

mute button, then please use star six so that we can have silence on the line. And when you are ready to speak, then please use star six. Thanks so much.

Ms. Munn.

INTRODUCTION BY CHAIR

MS. MUNN: Good morning. Those of you who have our agenda know that we're going to spend most of the morning taking a look at our new and vastly improved matrix system which Kathy Behling and Steve have been working together on for just about the last six months.

Isn't it about right, Kathy?

And I hope that those of you who need the information already have the material that was sent to you by e-mail. Kathy's going to give us her presentation with the expectation that we're going to talk about this probably a lot. And we will have one or two other items with respect to this matrix that we need to discuss while we're here.

One of the things that we'll need to discuss is how extensive the report on this matrix and how it's going to operate needs to be when the Board's letter goes to the

Secretary. That turns out to be a thornier question than it sounds like easily. I recognized when I had an opportunity to see the draft that SC&A has put together what the real problem is.

The real problem is that this is an extremely complex system. Describing it in a simplistic way briefly is a major issue. So at the same time we're going through these things I would like for all of us to have in the back of our minds is the serious problem of how to be concise and at and at the same time fulfill the need for full information that we need when we're going to be communicating with the Secretary.

That being said, Kathy, do you want to begin?

SC&A: NEW MATRIX FORMAT

MS. BEHLING (by Telephone): I'm ready to begin, Wanda.

Can everybody hear me?

MS. MUNN: We can.

MS. BEHLING (by Telephone): Okay, and as Wanda said, I hope that everyone received the information that first of all Wanda sent out

of my initial presentation. And then I followed that up with another one-page PDF. It's the term-server logon screen, and I hope everyone has that also. I did ask Steve Marschke to bring along hard copies for those in the room, maybe if you were unable to make a hard copy of that before you got to the meeting. So I assume you have all of that material.

MR. GRIFFON: Kathy, I don't have either one of those. When were those sent?

MS. BEHLING (by Telephone): I'll send them to you now.

MR. GRIFFON: Okay, thank you.

DR. ZIEMER: Those were sent the day before yesterday I believe.

MR. MARSCHKE: Some of them came yesterday.

MS. BEHLING (by Telephone): Wanda made sure she sent them. She sent about four different e-mails and some of them, the presentation was not in a zipped format. It was actually PDF format, and it says Kathy's past three matrix presentations.

MR. GRIFFON: Yeah, I got nothing from Wanda in the last couple days anyway.

MS. MUNN: You didn't?

MR. GRIFFON (by Telephone): I don't know.

DR. BRANCHE: I'll send everything to you now.

MR. GRIFFON: Thanks.

MS. BEHLING (by Telephone): What I'd like to do, first of all, let me explain why I asked Wanda if we could have an opportunity to walk through this Procedures matrix. I guess first of all I wanted to show you the changes that we've incorporated into the matrix for the purpose of making the data entry process a little more efficient for us. And then secondly, and I guess most importantly, I wanted to ensure that we've captured all of the relevant data and are developing reports from that data that serve the needs of our work group.

So whenever we go through this process again, and I know in some cases you've heard some of this before, and you'll be a little more familiar with it, but let's make this interactive and ask questions along the way. Don Loomis is on the phone also, and he's the developer of the database so when I can't

answer your questions, I'm sure he can. The only thing I would ask is how many cups of coffee John Mauro has had.

I think we can start with the one-page file that I, titled Term-Server Logon Screen. Does everyone have it available?

DR. BRANCHE: Yes, thank you.

MS. BEHLING (by Telephone): What that shows you is obviously when you get onto the term-server on the left-hand side and you can see where you're looking at the O drive. And underneath the O drive is the folder, the AB document review folder where we place a lot of documents for the Board.

In this particular case, NIOSH and ORAU have developed another folder underneath that specific for this database, for this tracking system, called Advisory Board-dash-SC&A. And underneath that folder is a tracking system folder, and, in fact, when ^ we will change ^ because I anticipate this is going to obviously be the Procedures tracking system, and I anticipate that possibly by even the end of the month when we have the Dose Reconstruction Subcommittee meeting we will be

in a position to have a draft of a Dose Reconstruction tracking system which I hope to make a presentation on or at least give you a draft of what that might look like at the end of this month.

And then what you'll see inside this current tracking system that exists on the folder that exists there, and that will be changed to probably Procedures Tracking System, that name. The first thing you see in the main portion of the screen, in the center, is called a folder called Reference Documents.

And that's going to hold all of our white papers and those documents that we're going to, in the actual database and in the findings. We're going to link our white papers and any records information into that folder. And so when you're actually in the database, and if you want to, you have findings that where there was a white paper identified, all the white papers written, you'll be able to click in that finding, and you will open up a PDF file and that'll come from this particular folder that will actually show you the white paper.

Underneath there you see three folders or actually three files, and these are your active database files with the first one being the Advisory Board on Radiation and Worker Health Procedures Issues Tracking and no extension behind that. And the other two folders, the other two files have a data and a local extension behind them.

So when you open up the database that you're going to be working with, you want to use that first file, the one that does not have data or local behind it. In fact I have a box around that one. It's the very first file there. And when you select it, let me also talk a little bit about the logon procedure, and then at the end of this discussion we'll have a little bit longer talk about log in and how we're going to handle this and what kind of access we're going to give to people.

But when you log onto the term-server, the database will know, based on your user ID, whether you are a person who will have read-only access or if you will have full access meaning you can make changes to the database.

That will be identified just by you logging in, and we'll talk about that a little bit later.

MR. ELLIOTT: All right, let me interrupt you. You're saying when you log onto the O drive?

MS. BEHLING (by Telephone): Yes.

MS. HOWELL: I had a question, Kathy. This is Emily Howell. I know we had mentioned this when we had our meeting in Las Vegas, and we had a Procedures work group there. What are our plans in terms of marking the document such as the white papers as having been or not yet been Privacy Act reviewed? Are we going to ensure -- I just want to ensure that there still is a header or footer on all of these documents that are coming up stating where they are in the process of being Privacy Act reviewed, whether they're publicly releasable or not.

Because I wouldn't want someone to print something off that they've accessed from the database and then disseminate it not realizing that it's, you know, the Privacy, it has not gone through Privacy Act review, and

that you're being able to see it because you're a government employee or contractor.

MS. BEHLING (by Telephone): That's a very good point, and we will certainly make sure that any information that gets into the reference document has gone through the Privacy Act and through you and through the Privacy Act process.

MS. HOWELL: I mean, it's okay with us. I mean, this is for, my understanding of this whole ACCESS database is that it's internal, and because it's internal it may be of use to SC&A and the Board members for these to be un-redacted, non-reviewed copies which is fine. But if that's the case, they just need to be clearly marked as such.

And I also wouldn't mind having some sort of system message that comes on when you log in stating once again these are government documents. Do not print them and make them available to others or something along those lines. I'd be happy to work with you on that language. I know you have some language that is typically put on documents that haven't been reviewed. So it's okay that they're not

reviewed. I don't think we're looking to review everything that goes on this, but we need some sort of message.

MR. ELLIOTT: I would like to expand upon that. This is Larry Elliott. I think it's come to our attention that it's very important that we identify when one of these documents, a matrix or a white paper or working document of the work group, is in its final form. It becomes finalized. We have many versions. You know, these are working documents. They're drafts. They're labeled in many different ways. I think we need to come up with a standardization of labeling and make sure that we know when we have arrived at a final version.

MS. HOWELL: So that we know what to review and make available if it is necessary.

MR. ELLIOTT: Well, see, I think it's complicated because as we work with these different work products of the working group, we may find ourselves being requested to release them. So you're asked to do a Privacy Act review under a FOIA request, and so now we have a version that's not a final version.

It’s a draft. It’s preliminary, and it’s been reviewed and redacted.

And then we go a period of time, a month, two months, a quarter, half a year, and all of a sudden we have a different version than what was previously made available, and yet it’s not final. So you see where I’m coming from? At some point in time we’ve got to -- and I’m not trying to push to closure here. I’m trying to push to the ability that you’re setting a record, a record of your deliberations, and you want to be able to show that this was the final version.

MS. HOWELL: And when that happens, I’m still not clear on exactly who’s going to have the ability to edit these documents -- and maybe we can go over that one more time -- but when that happens maybe if there’s some way to close the document on the system so that it can’t be -- I mean, we certainly need to have a really clear record of the edits that are made so that we can keep track of versions. I mean, that’s going to be a concern with us because of the likelihood of the need to release interim documents to claimants and

petitioners.

MR. ELLIOTT: Would it be good if I go over our practice or process, the policy at this point in distributing these documents? I mean, would that be helpful?

MS. HOWELL: Yes.

MR. ELLIOTT: Okay.

DR. ZIEMER: Well, could I ask you a question first? This is Ziemer. Are you only referring to the documents in that reference document file or to this whole tracking system?

DR. BRANCHE: Everything.

DR. ZIEMER: Everything, because we've already agreed for the most part most folks will not have the ability, just speaking sort of generically, the ability to change these documents except for a designated person from SC&A and a designated person from NIOSH, and that may be it, or a couple people.

MR. HINNEFELD: Perhaps the working group Chair.

DR. ZIEMER: Or perhaps the working group Chair, but in general, let's keep it -- and most people accessing this will not have the

ability to change anything.

MS. HOWELL: So can you, will you be able to set it up so that for a specific matrix, say the Mound matrices, Josie Beach is the working group Chair, and she would only have access to just that one matrix? Do you see what I mean? Because this whole working group Chair thing you have to be specific about what they can access and what they can't.

DR. BRANCHE: Well, she was using an example of Mound, but for this working group it would just be Ms. Munn.

MR. ELLIOTT: The editor and writer writes to this, you know, that's one thing. But maybe the way to control it is when the document authors or owners make a change to it, they submit it to somebody who can then replace the version. Maybe that's the way or add the version. I don't know.

DR. MAURO: I've been thinking about this dilemma and I've come, at least in my mind there's a bright line. From SC&A's perspective all of our work products, whether it's a matrix or a formal deliverable, is something that we deliver to the full Board,

NIOSH or the working group. And this is a product for NIOSH and the working group or the full Board.

The fact that some of that material, all of that material may or may not be of interest to folks outside of the working group, the Board, NIOSH, and want to participate, I see that as something separate. In other words from SC&A's perspective our obligation is to deliver as complete and clear a work product to the working group and Board. Very often we include deliberately information that's Privacy Act.

In fact, I have a report in my lap right now that I'm reading that has a dozen names in there. And they're important to have those names. We need to know who they are, and why their information is valuable. In fact, the instruction says do not redact. This is going to go to the Board, and you're going to need to see it. And what I'm saying now also applies to matrices.

In other words so then the question becomes, okay, SC&A has fulfilled its obligations in delivering the work product

that we're committed to to the Board, NIOSH and the working group. Now, fine, the other side of the line. Okay, we're about to have a working group meeting. We're NIOSH and let's put this work product on the web. That's on the other side of the line. And at that point in the process a decision -- and I'm not quite sure how this decision is made.

I mean, this is really a question. Yes, this work product needs to go through PA review so it's available to anyone who might be interested in looking at it. So in a funny sort of way SC&A is almost isolated from this problem because we deliver our product, and as far as I'm concerned, we're done.

MR. ELLIOTT: If I may, that segues into my explanation of our process and our policy on handling these kind of things. You're right. When you produce a product or when an OCAS author produces a product for the working group deliberations it's been a practice more tried than true upon this practice under our value of being as transparent as possible to reach out to the petitioner and explain to the petitioner that the working group is going to

meet. They're going to be talking about these documents.

And if we have them in our hands at that point in time, we can give them an understanding. If they want to request it, we'll get a redacted version available to them, but it will be redacted perhaps. It may not be a complete version. And then if anybody else is interested in seeing the document, they must provide a FOIA request. We take those verbally. We take them in writing. We take them by e-mail.

And our intent is to try to turn this around as quickly as possible, but you and I both know that we tend to turn things in at the eleventh hour, and you bring things in the day before. And so in many cases we're not going to be able to have a redacted version ready for the petitioner or an interested outside stakeholder until perhaps after the meeting has occurred.

So that's our dilemma. That's something we're talking about internally at NIOSH about how we can be more transparent and yet follow the protections given to the

program under the FOIA Act. Does that help? Any questions about that?

DR. ZIEMER: This is Ziemer. I have a question or a comment. I believe that NIOSH already has the ability, even on the O drive, to restrict who sees what files. For example, Mark Griffon, I tried to look at the Mark Griffon files on the O drive the other day, and it wouldn't let me. But your own set of files are there, right, Mark? The system has the ability to restrict who can go into particular files even within, and none of the members of the public as far as I understand --

MR. ELLIOTT: That's right.

DR. ZIEMER: -- have access to the O drive. So this is Board members, and it's on the O drive. It's protected and it's only when it moves out into the website, and that doesn't happen unless you guys have --

MR. ELLIOTT: It's our policy that we don't post these works in progress, the working documents, on the website. It's just too difficult to manage the version control.

DR. ZIEMER: And then the only issue is if

it is on the O drive, do I have the ability, for example, to download it, print it and suddenly make it available to somebody else. And that's what --

MS. HOWELL: Right, and that's my concern. I just want it properly labeled.

DR. ZIEMER: And I think there's where you need a caution on individual documents so that if they're still on the O drive to remind us that this is restricted. Or if it's not, but it's still on the O drive, that it's okay to make that public, right?

MS. HOWELL: And also --

MR. ELLIOTT: The first assumption should be everything that you touch in the O drive or in NOCTS is Privacy Act controlled, and before you could release it to some other party, you have to get an authority to --

MS. HOWELL: My concern is more that someone, a Board member, will print out multiple copies of something to have with them and then not realizing which version they have and just to say, oh, well, here, thinking that it, you know --

DR. ZIEMER: Or throw it in the wastebasket.

MS. HOWELL: -- right, and so I just say it's important for them to be properly marked. And also, if there were some -- and I think we talked about this in Las Vegas as well -- a mechanism to show that somehow the notes, what version has been printed. I thought this would be helpful not only from this perspective of controlling things that you've printed out, but also for Board members to show what it is they're looking at.

If they have a printed copy, is it an old copy? Which version is it? What date was it printed, and who was it printed by? And if there's a way to make that a default footer or something on the documents when they print, I think that that would be helpful.

DR. BRANCHE: You asked for that actually --

MS. BEHLING (by Telephone): Yeah, I agree with everything you're saying, and as you indicated, we know there are going to be Board members and those people who have access to the O drive that can actually get these documents. And I think for Nancy Johnson at SC&A we have established working with HHS in clearly marking all of our documents as to

where they are in the process.

And we can, we will work with you in any way we need to to have appropriate headers and footers and make sure it's very clear to all the Board members as to what version of the documents that we're looking at. And I think we already have a lot of that in place, and we'll continue to work with you through Nancy Johnson. We've sort of established one person at SC&A that can do this. And we will be very careful about the information that is put into this reference document folder.

But I'm certainly glad that you brought it to our attention, you know, the sensitivity of this because I have to admit my feeling was it is going to be Board members that are going to be generally looking at this, that this wouldn't be a problem. However, you are correct. I'm sure they will be able to have the ability to print these documents. In fact, I will show you a little bit later how to do that.

DR. BRANCHE: Steve wanted to raise a question.

MR. MARSCHKE: I was saying that as far as

the tracking system goes, I mean, controlling these documents, we could put a key in the name of the document whether it's been Privacy Act cleared or not. And then basically, based upon that key that's in the name of the document, we can either put a footer on it or totally restrict the ability to print that particular document. That would solve the problem from the tracking system's point of view and the document's point of view.

Obviously, if somebody were to come to this point on the O drive and instead of clicking on the tracking system, they were to go down into the reference documents and get to the documents themselves and do it that way, then that would not work for that. But to go, you know the way the document works we could put a key in the name of the document, whether it's been cleared or not, and based on that key then, you know, either add a footer or restrict the ability to print or do something along those lines.

DR. BRANCHE: This is Christine Branche. I just wondered if I could step back because we are talking about the ability of people to see

these documents, who sees these documents. And I just want to go back to something, Wanda, you said about preparing a letter to the Secretary.

Let me just make sure I understand this. Are you trying to make clarifications as to how you and Kathy were planning to make your presentation to the Board and how that information would be then conveyed to the Secretary or were you planning to write a letter to the Secretary? If it's the latter, why would you want to do that?

MS. MUNN: No, the former.

DR. BRANCHE: All right.

MS. MUNN: Not until John and the SC&A team began to try to pull together how we were going to report this significant change in the way we do business did we recognize this dichotomy that we had, how to convey adequate information without sending such a large document that would be unreadable.

DR. BRANCHE: Thank you very much. I think that was the last time -- this is Christine -- I think the idea of using the very liberal space that can be used to name a document, it

would be very helpful if you all would come up with a sort of a naming convention for documents I think you can settle a lot of issues about what's final, what's interim, what draft, what version, what date, and I would just suggest that you adopt a convention for all the documents coming from SC&A and frankly from NIOSH as well.

MR. ELLIOTT: Well, it's both, yes.

DR. BRANCHE: Thank you.

MS. MUNN: The nomenclature needs to be crystal clear to anyone, even the casual observer.

DR. BRANCHE: I will note that this is now the third time Emily's request for the printing issue come up because it was at a previous Procedures meeting.

MS. HOWELL: I have no problem, I mean, I would assume that pretty much everything on this database would not be Privacy Act reviewed because it wouldn't be helpful to the Board or contractors to have that, and that's fine. And with the printing I have no problem with people being able to print things.

I would just like for there to be some

sort of notations that is unchangeable that is printed with it showing the version, who printed it and all of that. So that if something inadvertently gets made public, we can at least figure out where the problem arose. And I think that would be helpful to Board members as well to know which version they're looking at because it seems like you could have a matrix that changes frequently. And we've had that issue in working group meetings before where people are looking at two different versions, so thank you.

DR. ZIEMER: Emily mentioned the knowledge of who printed it. Do we have the ability in the system if I went on the O drive and decided to print out something, do you know that, does the O drive know who's printing out something?

MR. HINNEFELD: Yes, yes.

DR. ZIEMER: Oh, it does? And so you could go back and track --

MR. MARSCHKE: We can put the name of the, basically the name of whoever is logged into the tracking system. We know that person, who that person is by, we get that information

from the O drive, and we can add that as a footer if you want. We can add that as a footer to any printouts that are made.

DR. ZIEMER: Other than just the print out, is there a log that somebody can go to and say, ah, Ziemer printed that out on that date?

MR. HINNEFELD: There's a log for the user, and I suspect that they could determine each activity of that user as they were logged in. I don't know that for sure.

MR. MARSCHKE: I think we have to check on that.

MR. HINNEFELD: They can certainly detect whether they've logged in.

MR. ELLIOTT: They know when he's logged in. They know when he's logged off.

MR. HINNEFELD: But I don't know --

DR. ZIEMER: ^ printed out.

MS. HOWELL: I think that's most important. I'm more concerned with the actual printed document having stuff on it so that if I randomly found a copy of something that somebody accidentally left on a Board table, I could say oh, this was so-and-so's. They printed it.

DR. ZIEMER: And it would have my name on it?

MS. HOWELL: And this is the version they -- right. And so it would have --

MR. MARSCHKE: It would have initials or --

MS. HOWELL: Right, some sort of login name that we could tell who it was, the Privacy Act warning, and what version of the document.

MR. MARSCHKE: Right now we just put the version of the document, we do put the version of the document on the printouts. I guess we could, --

You know, Don Loomis, if I'm saying something that's not doable, let me know, but --

MR. LOOMIS (by Telephone): Let me jump in at this point then. This is Don Loomis. There are two different ways that things are getting printed or can be printed. One is from when you're within the database itself. We have complete control. We know who's logged in. We can control what is printed and how it is printed, and we can change it on the way out.

The second way is people are logged

into the O drive, and it's just like sitting at your computer at home and looking at your C drive. You can print something and using the print command through the Windows operating system, but we have no control over that. So in the case of the white papers and supporting documents, reference materials, if it's printed directly, we can't touch it. We can't tag it. We can't change the headers or footers. If it's a report that we are printing within our system, then we can change it.

So I think that's the, if it's our material that we're managing directly, then we can control what's going on. If it's files sitting out there, PDF files or Word files that are being printed, we cannot manage what's going on. ^ in Windows. ^ that's going to involve the, how the term server itself is set up, and I'm not sure we want to get into the system at that level.

MR. MARSCHKE: If we can restrict access to the reference documents subfolder can be restricted to a very few number of users who basically, I mean, the same number, anybody

who has, you know, we could ask that NIOSH shut off the O drive so that that access is restricted so that people, you know, only a very few number of users can really get in there and have the ability to print those PDF files.

MR. LOOMIS (by Telephone): That would work in that case, but if you brought it up, for instance, where linking to these files from the database, it's just like on your web browser when you see a link, and you click it, and it brings up a PDF document. Now, we're doing the same thing. When you bring up a PDF document what you're bringing up is, Adobe Acrobat. And even now outside of our system, some call it the Adobe Acrobat Reader. And it's got control, and we cannot direct it.

And you can create the PDF document to not be printed, but then no one would be able to print them, so it would be viewable only online. But if they can be printed, then they can be printed, and we can't get involved in that process.

DR. MAURO: Let me jump in for a second. We're talking about there's work products that

are put out by NIOSH, the contractors and SC&A. We have an obligation if they have not been PA reviewed, they have to have a footer that says this has been PA reviewed. Whoever's looking at this, first of all whoever receives it, only can receive it if they're within that envelope.

This document right now that was printed out doesn't have the footer. We have to fix that so the footer's on. But I think once the footer is there and all of the folks within that envelope who have access and the correct right to look at, just like any other work product SC&A puts out whether it's a hard copy, and we send it to you by mail, or we send it to you electronically, it will have the footer.

And at that point, whether it's a Board member or someone from NIOSH or OCAS, they're going to physically have that document whether it's electronic or hard. And they have the obligation not to make a copy of that and send it off to the newspaper. They can't do that. That's what the footer tells them not to do.

So in my mind the controls we're talking about who went in, I mean, to me the most important thing is everyone that's using this, first of all, any product that comes off the O drive that contains one of these, whether it's a white paper that's linked to one of these spreadsheets, or it's a spreadsheet itself, whatever that material, unless it's been PA reviewed initially, goes on, is PA reviewed. And everyone has to be responsible for not, for controlling it as such.

And I think that's where we always have been except now we have this system. So I guess I don't understand why would we be concerned. People are not, you know, everyone has to be responsible and not leave copies out, un-PA cleared documents and send it out. You can't do that.

DR. ZIEMER: I think John's right because we get all kinds of documents. Larry sends them out now, the latest one we got this week, and it's unredacted, and it says on it that we're not to make it available. So this would be no different. So we have to rely on the

integrity of the recipients at that point.

MS. HOWELL: And that's fine. My concern with the who printed it was more for not so much controlling who might release it but because the version, you know, I can, that's not like a legal concern. It's more just for you guys internally to know which versions you're printing, and if the version is written on there then that's good.

DR. MAURO: The version control is essential.

MR. ELLIOTT: If it's a physical safeguard that the Board feels is necessary and appropriate, we can put it in place. If you feel it's restricting and obstructive, then we --

DR. ZIEMER: It's no different than your other products I don't think at that point. I don't see that we would see any, right, we shouldn't treat it any different just because it's on the O drive.

DR. MAURO: And your configuration control point of view I think you've already got it. In other words when you print out one of these on the lower right-hand corner it tells you

what version you're looking at. And so we can be sitting around the table and say, well, listen, we're all looking at 3/7/2008. And the answer is, yes, that means we're all in sync because we have had problems in the past with the other matrix when we, I was looking at last month's version, but now I think that problem's been solved by having that date.

And the only thing I think right now is missing is we don't have the footer on here that says this has not been cleared. And the question becomes though, this is a question I guess how best mechanics. At some point it may be necessary to clear because there might be a working group meeting where members of the public do want to sit in, and they do want to see this.

MS. HOWELL: But is there any need to actually have the cleared versions on this database? I guess, I mean, it's typically when they're cleared. I mean, OCAS has control of them, and at some point when it's the final version, it may go on their website cleared. They may control a cleared version that's an interim version that may go to a

petitioner.

But is there any need for there to be a cleared version on this because if a working group chair wants something to go to a petitioner, they should be operating through OCAS. They shouldn't be sending the cleared version themselves. So it may be kind of a moot point for your database. Just, you know, everything on it is restricted. Everything on it is not, has Privacy Act information included. And if you need a cleared version, then you go through OCAS.

MR. MARSCHKE: But the database is something we could continuously, or supposedly continuously, update it. And so to have it continuously, it would have to be continuously cleared because --

MS. HOWELL: Right, and that's not possible.

MR. MARSCHKE: -- every day we could go in and make changes to it in theory. And so every day we'd have to have it cleared. So that really doesn't, I think the best thing to do is like John says, maybe put a little thing in the footer saying any outputs from this database have not been Privacy Act cleared and

to handle them as such even though I don't know that there'd be any Privacy Act information in it, but we still have nothing cleared.

MS. BEHLING (by Telephone): Let me ask a question here. I thought initially we were talking about just the supporting documents and the white papers. It sounds to me though we're also talking about the matrix itself at this point now. It would be my understanding that the Procedures tracking database and the matrix that's developed from that database would not contain any Privacy Act information. Now potentially when we get into developing databases for the other type of work such as our dose reconstruction work, that may be certainly different. But am I understanding correctly that we're now talking also about having this type of footer on the matrix itself?

MR. HINNEFELD: Kathy, this is Stu Hinnefeld. I'd like to comment. I tend to agree with your opinion that it's unlikely that there'll be Privacy Act information in the Procedures tracking system. But on the

other hand since, you know, if this material is to be made public, it needs to be reviewed.

I think it's probably needed to have some sort of system in place to ensure that things like this are not released and there is a PA review of it before it is released. I kind of agree with your opinion, but I don't think we can just automatically assume that there'll never be any Privacy Act information in here.

MS. BEHLING (by Telephone): Okay, all right, I just wanted to clarify we were talking about for this database, if it was going to be just the white papers and supporting documents or were we also talking about the matrix. But we might as well be consistent and also do the PA-cleared issue on the matrix itself.

The only other comment that I would have with regard to incorporating ultimately cleared white papers into this database is it's my understanding that we want this to be a complete picture from the initiation of a finding 'til it's resolution and to what has happened with that particular finding. And

this is supposed to be an archive. And I would imagine that we will really want to include the various maybe versions of the white paper and then ultimately the final version and the cleared version just so that we have a complete understanding of a particular finding, of what happened with a particular procedure. I don't know if others agree with that or not, but I felt --

DR. ZIEMER: This is Ziemer. I would offer the opinion that the cleared version actually is less informative than the uncleared. So if you want something that you would call final, it would be the original, uncleared version. And this database is to help the Board track issues. I'm not sure if there's any necessity that it be made public. Is that a transparency issue do you think?

MR. HINNEFELD: It's hard for me to predict.

DR. ZIEMER: I mean, if we're going to discuss it at an open meeting, and when we need printed copies of some version of it, obviously we'd have to have somebody take a look at that, I guess.

Right, Emily?

MS. HOWELL: Yeah.

DR. ZIEMER: Otherwise, as was pointed out, this could be in principle changing their release for every few days or whatever it may be.

MS. HOWELL: I'm sorry to interrupt. There is a chance that in the course of an administrative review or in litigation that there would have to be kind of a freeze and that the information un-Privacy Act reviewed would have to be made available. Also, I think that could come up during a Congressional request for documents.

DR. ZIEMER: That could be done as needed I suppose --

MS. HOWELL: Right, that but that's a completely separate issue.

DR. ZIEMER: -- on this certain date. Here's the --

MS. HOWELL: Exactly. So I don't see, I think we had discussed previously the whole making public transparency thing. And I think it's not, I think we decided, and Larry has left and maybe Stu remembers that the database itself is kind of like the O drive. The

database itself is not public.

The documents that are on it can be made public, but in order for them to be made public, it's like a case-by-case, document-by-document basis where the review occurs. And the only situation that I could envision where a document that had not been reviewed for Privacy Act concerns would be made public without some sort of, like where some of the information that would otherwise be redacted might be included would be in the situation of administrative review litigation or a Congressional request.

So I think we need to look at the documents as potentially being made public, but we don't as a matter of course make them public because they are by their nature draft, pre-decisional documents and anything being made public would go through additional steps of review.

MS. MUNN: Let's think for just a moment with respect to white papers and what Paul just stated regarding each of the various drafts that come through. Is this likely to involve more than one or two versions? My

concern is, again, one of volume.

MS. BEHLING (by Telephone): I believe based on what we've seen so far -- and others can correct me -- it seems to me that when a white paper is generated, we don't go through various versions of it or revise it very much. It's simply a document that is generated sometimes by SC&A, given to NIOSH so that we can better explain our position on things. It's not something that goes through a lot of renditions. I don't view it as that formal.

DR. MAURO: I think Wanda brings up a question that we didn't talk about before, and this has nothing to do with the PA part of it now. I think the PA part is clear. The question becomes white paper. Let's say the Board directs NIOSH to prepare a white paper in response to some issue, and they do. It goes up on the O drive. And at some point in the process revisions are made to the white paper that was dated this date. And now we have a revised white paper. Do we need to keep track of each revision?

And this can be very much a living process because, if you recall, the intent was

that the white paper is a tool that will allow SC&A and NIOSH to iteratively come to resolution whereby a white paper is put out, and there's commentary. And because that could turn into a living document, the white paper itself, because it's a work product that's going to mature right up to the day of the next working group meeting.

See, I guess that's what I had in my head. This was the tool that was going to allow NIOSH and SC&A to address an issue that was raised by the working group, put it on the record, and it might actually iteratively change right up until the date of the next working group meeting where that white paper would be discussed.

Now, the problem I've been seeing, I mean, now to get into document configuration control and the record. We do lose this iterative process if we -- in other words, this white paper may go through iterations. It may go through iterations during one cycle, you know, prior to the next meeting, or it might go through a cycle for this meeting.

Then you may say, well, listen, we

made a lot of progress with this white paper but I think we need to do this, this and this, and then another version, a revised version, of that white paper might be worked on in the next meeting. Do we want to keep track of every iteration? That would be, I have to say, extremely cumbersome and burdening to the process.

MS. MUNN: That's why I bring the question because --

DR. MAURO: It's a legitimate question, absolutely.

MS. MUNN: -- I was interpreting what Paul had suggested earlier.

MS. HOWELL: Can I, if I could interject for a minute, and if Liz is on the line, she might want to chime in. I think that if what you're talking about is revisions to a white paper between presentations to a Board working group, say you have a white paper, and OCAS and SC&A discuss, and then it goes to a working group meeting. Then they take it back, and they make some more revisions. It goes back to a working group meeting. I think you have to keep copies of the white paper as

it is presented to the working group.

Now, if there are iterations where it's just OCAS and SC&A making changes, and then there's ultimately only one version that ever makes it to the working group, that may be a situation where you only need to keep one copy. But if different versions are given to the working group, we have to have copies of those available for administrative review purposes.

DR. MAURO: So the trigger is each working group meeting. That is, whatever is issued and used at a working group meeting, that becomes an official document. Then if it changes again for the next working group meeting, that's rev. two.

MS. HOWELL: Right, and if there are versions --

MR. HINNEFELD: Wouldn't that be a distribution to the working group? Because, I mean, we overtly, you need to overtly send things to the working group, before we overtly send things to the working group or Board, each time we would do that on a particular document, that's the next ^.

MR. MARSCHKE: My question is do you do that in this issues tracking and part of this issues tracking matrix or does the white paper have its own separate folder on the O drive some place where the history of that white paper is tracked and maintained separately? I mean, I don't think this issues tracking matrix was set up initially to track the evolution of white papers.

And the question becomes then what version of the white paper -- at some point we're going to say, okay, the version of the white paper addresses the problem that it was initially designed to address. We bring that version into the reference document file here and then we have the tracking system reference that final version or whatever.

But it doesn't really necessarily have to track the whole history in this tracking system. I think that would be done some place, you know, all the evolutionary versions would be maintained and filed wherever they're being maintained and filed now.

MS. MUNN: Paul, these are the questions that were coming to mind.

DR. ZIEMER: Sure, but let me respond to that in part I think. If your tracking system follows, you have a series of discussions and back and forth. And if the only reference document in the document files is the latest version, the earlier discussions may make no sense. Do you know what I'm saying?

In other words someone would say, well, the white paper doesn't say this. Why did they discuss it? It seems to me it would be very easy to have in the document thing rev. one, rev. two, rev. three, and in the discussion if it says we're discussing rev. one, someone could go say, oh, that's what the issue was. And now that's been resolved and then as you track along any discussion on a particular paper you will see where the changes are made. And someone could go back and look at an earlier rev. if they wanted.

But once it's in the system as an official document, it seems to me it sort of is there. I don't think we have to track it so much as to keep, you do have to keep track of what version you're discussing, it seems to me, as you move along through the regular

tracking system. If we're discussing a thorium issue, we want to know that the current discussion is based on rev. three of the thorium paper, whatever it may be. Do you follow what I'm saying?

MS. BEHLING (by Telephone): This is Kathy Behling. I actually agree with you. And let's remember this is a database. That's what databases do. They collect all the information in them. And I don't think there will be any difficulty in having a folder, and we can make subfolders, or however we want to, separate this data out.

But under this reference document, we have a discussion white paper that's discussing a certain topic. And as you said, we have rev. zero, rev. one, rev. two, and we can follow the correction. My feeling was that this database was to get an archive of what has happened from cradle to grave with all of these issues that we're discussing. And I don't think that that's a problem at all. And maybe Don Loomis can weigh in.

MR. LOOMIS (by Telephone): I agree completely.

DR. MAURO: But let me go back because I thought there was general agreement that it's the trigger for making it a rev. one, a rev. two, a rev. three is the working group meeting. That is, there's going to be a lot of give-and-take prior to a given working group meeting relating to an issue. White paper may very -- now here's mechanistically a white paper is produced.

Let's say it's produced early in the cycle before the next meeting. The next meeting is out here. Here's the meeting over here, okay? You say SC&A and NIOSH, please look at this issue. And we start looking at this issue and material is exchanged, or let's say conference calls are held, these technical conference calls. But some place along the way we agree. SC&A says, okay, here's the white paper we're putting out. Or NIOSH says here's the white paper we're putting out.

It gets into the system and becomes just like the matrix, it becomes the white paper that goes with this matrix that's part of the package. It's going to be discussed at that meeting. Now, if it turns out at the

next meeting more work needs to be done on the very same white paper because we discuss it, and there's a need for more work to be done.

What I heard is that then a rev. to that white paper would be put into the system, so in the system you have rev. zero. You have rev. one, but they all would be keyed to a working group. Now in between the meetings there's an awful lot of stuff going on. And I don't think we're going to track that stuff.

MR. ELLIOTT: I don't think we're asking you to. You wouldn't see that on our site except for the individual authors, and they keep track of the revisions they go through. But once a document is put into discussion that is the trigger.

DR. MAURO: Yes.

MS. BEHLING (by Telephone): Exactly. And then it would all be captured in the actual database and in the record for that finding is the fact that the Board will direct either NIOSH or SC&A to reevaluate this white paper or for SC&A to evaluate a white paper that NIOSH has just submitted. And so that in itself will, the next time there's a work

group meeting, it will indicate that there should be another white paper or a revised white paper out there or a response to a white paper.

Also, any directives that the Board gives us will be captured in the database, but we don't want to get too carried away with how much data we're collecting here. Obviously, there are things going on in between working group meetings, but as long as we can do a trail, look at a trail, I think that's adequate.

MS. MUNN: Paul?

MS. BEHLING (by Telephone): The database will do that for us.

DR. ZIEMER: One other observation, I think in many cases the issue is not to revise the white paper. It's to resolve an issue.

MS. BEHLING (by Telephone): That's right.

DR. ZIEMER: And so unless there's some reason to go back and say the original white paper is somehow deficient, it seems to me you could take an issue out of the white paper and an issue itself could be subject to discussion. We say, well, we have to resolve

this. We're going to carry it to the next meeting. But we don't necessarily have to go back and say let's revise the white paper because the white paper was simply something to initiate a discussion.

MS. BEHLING (by Telephone): That's right.

DR. ZIEMER: In many cases --

MS. BEHLING (by Telephone): -- by saying I don't anticipate a lot of versions of a white paper.

DR. ZIEMER: -- unless there's some reason to feel the white paper is so defective it has to be either NIOSH or SC&A says I don't want this to be the final version of a white paper.

DR. MAURO: I've got a great example. On Nevada Test Site we had at least three or four sequential work group meetings dealing with resuspension factors, and each time our thinking matured. And we started off with one approach that was offered up by NIOSH. At a meeting SC&A came back. We actually issued, Lynn Anspaugh issued a white paper. It became, and it went off.

And then what happened next step is a new white paper was issued by NIOSH which came

up with a new approach. So the white papers were, at least that's like a perfect example, a series of SC&A and NIOSH white papers. Eventually this process came to a resolution. Yes, we like the new resuspension model.

DR. ZIEMER: But you didn't have to review the white paper.

DR. MAURO: We didn't review any, that's right. We didn't review the white paper. What happened on the end is there's going to be a revision to one of the site profiles that deal with resuspension factors that's going to reflect this.

DR. ZIEMER: Right, the white papers were just a vehicle to start to focus your thinking in some direction, and they stay as they were.

DR. MAURO: They did stay as they were.

DR. ZIEMER: Not that they were defective per se, they were vehicles to initiate a discussion.

DR. MAKHIJANI (by Telephone): Could I say something here in regard to the site profile? This is Arjun. What happened, if I remember correctly, with these white papers is after NIOSH issued its white paper, we didn't

actually write another review document. But there was a lot of discussion about that review document. So not everything in it, while we felt the NIOSH white paper went some lengths to address the issues that we had discussed and so on, it came up with a new approach.

Not everything in the new approach, there wasn't a full resolution if you just looked at the papers, and there was further information in the actual working group meeting that took place that Kathy reflected in the kind of record that we're talking about. That would be a very difficult kind of --

DR. MAURO: Arjun, in the end it's the transcript that's the final word. In other words I think that what we're doing is we had a transcript. Everything is captured there. In a way what we're saying now is that we're trying to somehow create a tracking system that captures the essence of what transpires at every working group meeting where issues are being addressed. And sometimes white papers are a very convenient tool.

But the reality is if somebody really wants to go back and recreate an entire sequence, I mean, I think that even our tracking system is not going to be as complete as the transcript. That's our final safety net that we made sure we've got it all right. So I think we can't make our tracking system as complete as the transcript ever.

DR. MAKHIJANI (by Telephone): No, I agree with that. I just wanted to throw out the caution that somehow if there is an idea, I think the Task Three thing is a little bit different because in Procedures there is, you know, generally a more clear resolution at least as I follow those discussions. In site profiles it's often not so clear, and so the idea that white papers somehow this tracking system would reflect that resolution is less convincing to me, I think, as we are actually doing things that would ^. I just want to throw out that caution.

MR. ELLIOTT: Well, I think you really have a matrix and the issues from the site profile review and white papers that address some of those issues, the resolution or the progress

is captured in the matrix. Is it not, Arjun?

DR. MAKHIJANI (by Telephone): Yeah, no, that -- is that Larry?

MR. ELLIOTT: Yes.

DR. MAKHIJANI (by Telephone): Yeah, exactly right, and I think maybe I'm just growing old. I think that for site profile that thing is working, and we're introducing it into the SEC framework now in a slightly modified form. And yeah, so, I agree with you then that seems to work.

DR. MAURO: So going back to the original rationale, Wanda, during the meeting, at the end of the meeting, you make a list of action items.

MS. MUNN: Yes.

DR. MAURO: And you say, okay, you do this. You do that. And one of the things is we write a report for NIOSH on this subject which simply says that between now and the next meeting you'd like NIOSH to put out a piece of paper that would address this issue. But to me now, how they get there, whether or not there's some dialogue going on prior to them putting that piece of paper out, it's almost

like transparent to your request.

MS. MUNN: Yes.

DR. MAURO: Your request is very simple. You want a piece of paper distributed and part of the record, and that's what triggered it. So as far as I'm concerned at the next meeting it's there, and it stays there because that's what you asked for, and it's there. And it's going to be there on the record. Now what happens after that, happens after that, and you will give direction.

Now, that direction might be issue another white paper to supplement this, and that would be your direction. At that point in time it seems to me you may say, listen, I'd like you to revise that white paper, a revision of it, well, the first version is still there. It never goes away. The next one that comes out whether it's a new one or it's a revision of that one, that's in there and stands on its own for the purpose of the next meeting. I think it's simple.

MS. MUNN: I think so. If nobody minds, at this moment I'd like to back up just a little bit. It seems to me that we've gone a little

far afield, and there are two --

MR. ELLIOTT: We apologize to the Chair for taking you there.

MS. MUNN: That's all right. There are two things I want to verify. First of all, Mark, are you still there?

MR. GRIFFON (by Telephone): Yeah, I'm here.

MS. MUNN: Did you get the material that Christine sent you?

MR. GRIFFON (by Telephone): It came through, yeah, thanks, Wanda.

MS. MUNN: Okay, so now you know essentially our agenda, and you have Kathy's material, right?

MR. GRIFFON (by Telephone): Yes. Thank you.

MS. MUNN: Very good. I need to verify with you after this is all over with why my messages do not get to you because you should have at least five, possibly six, from me. Is it the right e-mail address?

MR. GRIFFON (by Telephone): I'm not sure. We can clear that up, yeah.

DR. BRANCHE: We just found out that she had the wrong e-mail address so we'll correct

that.

MS. MUNN: All right, we'll take care of that.

And now, Kathy?

MS. BEHLING (by Telephone): Yes.

MS. MUNN: Where were we?

MS. BEHLING (by Telephone): I don't know.

DR. BRANCHE: We were at the very beginning actually. You can begin again.

MS. BEHLING (by Telephone): I guess we're a little bit -- I don't want to say sidetracked here because these are very good discussions, and I know that they need to take place. I think quite honestly I look at this in a much more simplistic format. I think sometimes we lose track of where we're going here.

We've been having these types of meetings, and we've been dealing with these procedures in dose reconstructions and site profiles for some time now. All we're trying to do at this point is capture the most important data. And as I started out saying the goal today is to ensure that we are capturing the relevant data, and that we're producing reports that will serve the needs of

the working group.

But while we're on this discussion of accessing this information, I was going to wait until the end to maybe have a little bit of this discussion, but while we're discussing this, it might be appropriate. One of the things that I wanted to discuss with NIOSH, and I assume ORAU and Kay or whoever, is the fact that this is the term-server and this is honestly ORAU's database and their server.

And so I wanted to be sure that we, SC&A, just a select number of individuals again, would be in the position to load the information ourselves into the thing such as the reference document folder. And I feel that this is appropriate because, as I said, we already have something in place to ensure when things are not PA reviewed. We have a footer on there, and when things are PA reviewed, we can load that information.

But is it appropriate for SC&A individuals such as myself or Steve Marschke here or Don Loomis to load documents onto this database under a folder such as the reference documents? I'm just thinking about the

mechanics of this. We have the ability to do that. We can do that through the secure FX; however, I want to be sure that we do have permission to do that.

And we can also set up some type of protocol that once that's done, we inform either up front, we're about to load this data, or that's different than making changes to the database. Obviously, I think we've already gotten permission to have someone like myself or Steve Marschke go into the database and update that information. But I'm talking about loading new information such as these white papers onto the, or is that something we need to send to NIOSH and ORAU and they need to update?

MR. HINNEFELD: No one is saying anything. This is Stu Hinnefeld. I don't see any reason why SC&A shouldn't load those directly.

MS. BEHLING (by Telephone): Okay.

DR. ZIEMER: You mean just notify you or how does that work?

MR. HINNEFELD: Well, I think it would be a notification probably to the working group and to us just like when we put anything up we

notify the working group and SC&A that a new file is out there. Now actually for us to load, I may have to have offline discussions with Don and Kathy about how this ACCESS database will work if we're going to have users on our side.

MS. BEHLING (by Telephone): Yes, in fact, I was anticipating that you would have an opportunity to call Don yesterday and that we could --

MR. HINNEFELD: Yeah, I'm sorry. I got tied up. Between being out of the office for five hours and then having three hours to prepare from all my messages from the night before, I'm sorry I did not call Don.

I apologize, Don. I completely forgot.

MS. BEHLING (by Telephone): That's not a problem at all. I just had to tease you a little.

MR. HINNEFELD: Tease Wanda a little bit, too.

MS. BEHLING (by Telephone): I guess then let me take it one step further. Don and I are already thinking ahead to our Task Four

tracking system to our dose reconstruction tracking system. And as I indicated, if we look -- we're still on this first screen -- if we look on the left side underneath is Advisory Board-SC&A there'll be, the current tracking system will say maybe Procedures Tracking System.

The new Task Four tracking system may say DR Review Tracking System. It would be nice also if Don or Steve or Steve or Don would be more qualified to do it, loading, once this database is available, loading that information onto the database.

And one of the things that we've talked about ostensibly is linking findings, and Don is also working on that. And I'm envisioning something, and I'm just talking off the cuff here because Don and I haven't explored this, if there was a finding in the dose reconstruction review that we decided needs to be placed in the Procedures review, that link would be made in this area.

And it would show up, that finding would show up on the tracking system maybe with a status of open-imported or something

along those lines. And there would also be a trace from the Dose Reconstruction Tracking System that said this particular finding was transferred to Finding such-and-such or in Procedure number on such-and-such a date. So you would have a link between the two, and it would be a clear understanding of where that finding went so that as we've talked about nothing falls through the cracks.

MS. MUNN: I really like that open-imported concept, and that's been bothering me a lot.

MS. BEHLING (by Telephone): It came to me during the night.

MR. HINNEFELD: Kathy, Stu Hinnefeld here, one question. Well, in looking at the Procedures Review database then, at a, say it's a detailed finding or whatever, will we be able to look at that and know which DR findings have been linked to it, if any?

MS. BEHLING (by Telephone): Yes. Yes, and we'll get there.

MR. HINNEFELD: Because, I mean, it could very well influence what you write in response to the finding if you know there are other findings that that response needs to address

as well.

MS. BEHLING (by Telephone): Again, I believe I can say yes to that. And when we get into our detail screen a little bit further down the road here, remind me of that again and be sure that I've properly answered that question.

DR. MAURO: Hold it. I heard something that I don't know if I agree with. If we're in the matrix dealing with procedures, we're dealing with a procedure that applies to every site profile -- I'm sorry, every dose reconstruction and could influence all of these. I'm assuming you just didn't say you want to we want to send out a link back that way.

MR. HINNEFELD: No, no.

DR. MAURO: It would go the other way, the other way.

MR. HINNEFELD: In dose reconstruction review there are many findings that has been deferred to this working group because there is a procedure we will review that will address it, and it's only those decisions.

DR. MAURO: So it's in the DR review matrix

that links you back that says see Procedure so-and-so which, okay, I was afraid I heard the other direction. You can't have the other direction.

MS. MUNN: Mark is very happily closing out his items by sending them to us.

MS. BEHLING (by Telephone): And, John, again, am I speaking out of line?

DR. MAURO: You're doing fine. Kathy, I'm getting another cup of coffee.

MS. BEHLING (by Telephone): Okay, should we continue here?

MS. MUNN: Yes, please.

MS. BEHLING (by Telephone): Okay. Let me go on a little bit more about access, about getting access to the database. One of the things that we at SC&A were doing yesterday is I, as I said, currently, Steve Marschke and myself have full access to the database meaning we can write to that database. John, I did not give John full access yet. He has read-only access so that we could test for things.

And when Steve was out on the database, and I tried to log into the

database, as of yesterday I am getting an error, and it will not allow more than one user whether that user, I thought initially that it might be because we both had full access, and so the database would not allow us both to be on at the same time so that there couldn't be a change in records without one or the other knowing about that. But it is also happening when John was on who has read-only access, and I tried to log on. I'm getting the same error.

We have sent an e-mail to the technical person at ORAU, and I believe Don indicates that there should be no problem, he thinks, resolving this because ACCESS itself is set up that you can have multiple users. In fact, you should be able to have multiple users. If Stu, even if Stu Hinnefeld who will have access to write to the database, and I were both on that at the same time, and we were making changes to the database, there would not be a problem with that.

It would only create a problem, and again, the system would stop us from doing this, is if we both tried to make a change to

the same record. It wouldn't allow us to do that.

Am I correct, Don?

MR. LOOMIS (by Telephone): Yes, that is correct.

MS. BEHLING (by Telephone): So one nice feature about ACCESS about using the system is that ultimately we should all be able to get on, and we can very well track who gets what kind of access. And it should not create any problems in ACCESS when there are changes or updates being made to this database.

MR. HINNEFELD: And this would apply to ORAU as well. If we had an ORAU person authorized to write to the database. When they would try it, it would have the same protections because they would be logging into the O drive version, the same version of the database you are. Is that correct?

MS. BEHLING (by Telephone): Don, yes?

MR. LOOMIS (by Telephone): Yes, as far as I know. We have to find out the specifics of how you connect through.

MR. HINNEFELD: Yeah, well, I can talk to you offline. I don't connect. The things on

the ORAU O side that we see are replicated to our side. So I cannot deal in the normal fashion with this database, so we'll have an offline discussion. It may have to be ORAU would update it each time.

MR. LOOMIS (by Telephone): Okay.

MS. BEHLING (by Telephone): Let's see if there's anything else on this first page that I wanted to mention. I don't believe so.

So now we can go over to this separate file that was sent to you by Wanda, and it's actually page one of what I have marked on the footer as March 13, 2008 Presentation. And once you get past this initial screen -- and let me go through it one more time.

You log on to the term server. You get onto the O drive. You get into the Advisory Board-dash-SC&A folder. You open up the Tracking System folder, and then you open up the ABRWH Procedures Issues Tracking file without the data or logo behind it. When you select that file, you will see page one of my presentation, which is your summary screen. Does everyone have that before I start?

MS. MUNN: Page one of 472, right?

MS. BEHLING (by Telephone): That's right. And in fact, that 472 let's you know how many findings have been entered into the database at this point in time. Between Steve and I, we've hopefully, I'm not saying it's a hundred percent correct yet, but hopefully we have entered everything from the first, second and third set of procedure reviews as well as the supplemental procedures that we had been asked to look at such as PROC-0092, PROC-0097 and OTIB-0052. So that should all be, all of those findings should be identified in the database at this point in time.

And on this summary screen, and the way you know you're looking at the summary screen, if you look at the top left the tab that says summary shows it's white as opposed to being gray. And that shows you you are on the summary screen. Now one of the changes that we've made to this summary screen -- and again, these are changes that we felt would help the data entry process and be a little bit more efficient in entering the data and be helpful to the data entry person.

It's not going to affect necessarily

the reports that you're going to be printing from here. One of the things that I wanted to be sensitive about is that we did not change anything that ultimately would be printed unless the Board approved that change. And we'll get to that a little later.

But on this summary screen the first thing we did was expand the Procedures ^ column a bit because we do have in there the rev. numbers, and at times, if you were to scroll down you'll even see whether it was just a page change one. And so we need to expand our column so we could see completely what we were dealing with and what revision we were dealing with on these findings.

The other thing that has changed here is in the previous version under the column that is now marked SC&A Findings, that used to be our Procedures title. And so you would see the same title down there. In fact, the page that I printed out here would show you that this is the external dose implementation guideline, and that would be repeated all the way down through.

We felt that it may be more beneficial

for us to have actually the findings listed there. And so we changed that field. But again, if you want to hit the print summary screen at this point, it would not print that finding. It would print actually the Procedures title as it has in the past.

MS. MUNN: Oh, how interesting.

MS. BEHLING (by Telephone): And we can talk about that when we get to the print screen because if you'd like to see something different in on the print, we can make that change. I just decided not to make any changes to the print screen until we have the approval of the work group.

And there's also -- and I won't get into the status on this particular screen. We'll talk about that later. But again, when the summary screen, we're just seeing a roll-up of everything in the database. And currently the screen that you're looking at, I have not filtered any of the data. This is a complete listing, and as you see at the bottom, we're looking, I have my cursor in the first row of 472 records.

Now if we go onto the second page,

I'll also tell you some additional information that was added. And again, this is in order to help us when we add the data. If you put your cursor into the second column under the procedure number, and you hold it in that column, a pop-up box comes up. And as you can see it tells you what procedure you're dealing with if it's your external dose reconstruction implementation guideline that was on earlier.

And I'm showing you on page two that pop-up so that you're able when you're in the database you will hold your cursor over there and actually see the name of that procedure if you took it out of the other column.

MS. MUNN: Okay, so you went to a whole other procedure though other than the ones we were looking at on page one.

MR. ELLIOTT: No, same procedure, just put your cursor on the first one --

MS. BEHLING (by Telephone): The same screen, all I did was put my cursor in the second column, first line and what popped up was external dose reconstruction implementation guide.

MS. MUNN: Right. Sorry, Kathy, I'm several

screens ahead of you.

MS. BEHLING (by Telephone): That's okay. I'm taking too much time.

MS. MUNN: No, you're not. No, you're not.

MS. BEHLING (by Telephone): Okay, and if we go on to page three, again here is a second pop-up box that Don has incorporated, and that's the finding itself. Under the SC&A finding, obviously, these can sometimes be lengthy. And so I again put my cursor in that first finding and it brings up a pop-up box that gives you the entire, spells out the entire finding for you so you can see what the entire finding is when you're still in the summary portion of the screen.

MS. MUNN: Just a moment, Kathy. Paul has a question.

DR. ZIEMER: This is trivial actually, but why do you change fonts from your main page to the other pages? I just happened to notice you go from Tahoma to Times New Roman. Is there some significance to that or did it just turn out that way?

MS. BEHLING (by Telephone): Don?

MR. LOOMIS (by Telephone): It just turned

out that way. I've been using Tahoma for the, I actually used two different fonts regularly, one for data and one for titles.

MR. ELLIOTT: We're having trouble hearing you, Don.

MS. BEHLING (by Telephone): Don, can you speak up and repeat your --

MR. LOOMIS (by Telephone): Yes, I'm sorry. I do usually use two fonts, but it's to distinguish titles from data. I usually use Arial for titles and Tahoma for data so Times New Roman is the one. There's no other significance. I usually use Tahoma for all of the data.

DR. ZIEMER: Oh, okay.

MS. MUNN: Makes sense.

MS. BEHLING (by Telephone): Now if we move on to page four, we're looking at our detail screen, and again, we know we're on the detail screen because if you look at the upper left-hand corner of the screen, detail is now in white and obviously we see a change in the screen. One of the things that we added to the screen at the bottom is when we were loading this data, Steve made mention,

wouldn’t it be nice if we could just go from one detail screen to the next detail screen without going back to our summary to pull up that detail.

So Don has added the next issue button and the previous issue button at the bottom, which allows us to go back and forth on the detail screen without going back to the summary.

MS. MUNN: That’s a very nice addition. Thank you, Don.

MS. BEHLING (by Telephone): And Steve recommended that. He was loading a lot of this data.

Also, the color-coding changed a little bit. We were not happy with that color-coding, and we named that lower portion where we’re actually putting in the workers’ information a little bit smaller. And here again we have to remember when we’re in the database, this is just our tool. I don’t necessarily anticipate -- and I may be wrong here and the Board may become quite comfortable with the database -- I expect most of the time you will want to generate a report

from this database.

I'm not sure if you're going to spend a lot of time going in and looking at the details, but that's certainly an option. But that's why we made this lower portion a little bit smaller, and when you put your cursor in here, you can see the entire discussion. But obviously, when you print it out, everything will be printed on one page for this particular finding, and everything will, obviously, you'll be able to see it clearly. So nothing else has really changed here, it's just that we did add the previous and the next and did a little bit of color-coding.

The next page, page five of the presentation, shows another feature that we added. And again, this is Steve Marschke's recommendation, which I thought was a very good one. The status, we wanted to make sure that you couldn't put just anything into the status. We've obviously come up with a select number of things that we feel are appropriate to put in that status box.

So Steve said why don't we have a drop-down box so that we can select that. The

only concern that I have about that is because as we know for issues such as transferred, you have to have a secondary drop-down box so that you can type in where did they transfer to, and right now it's typically a global issue, and we'll see that in the next screen.

But I wanted to point out on page five that this is our drop-down box, and these currently are the status that you can choose from: addressed in findings, closed, in abeyance, open, open-in progress, and transferred. As the other databases, as I indicated, as we develop other databases another status in here may be open-imported so that we can sort on anything, any finding that may have come in from another group. It's just something we can speculate and think ahead about.

DR. MAURO: Kathy, what does "addressed in finding" mean?

MS. BEHLING (by Telephone): Okay, I have a, I show that in detail on, let's just move on and then I'll discuss that.

On page six I gave you again, now once you put in transfer, this sub-box comes up,

and you -- right now it says global issues because that's the only thing we're transferring to and so that's available. And you type in global issues. Now when you print this it will still show as transferred and then global issues behind it in parentheses.

Now on page seven I can answer your question, John.

DR. MAURO: Okay.

MS. BEHLING (by Telephone): Page seven, addressed in, and this is where a lot of times we have a finding that this particular finding was initially a finding under OTIB-0004, but it's going to be addressed under a procedure now, which is PROC-0061. And we direct you to where that finding will be addressed. And that's what that status means. And so again we need a secondary drop-down box so that we can actually type in where that finding is addressed.

I used a somewhat unique example here because typically what we've been doing, I think it was in PROC-0092 discussion, we said there was so much substance to be answered in Finding Number 1, we said once we answer

Finding 1, we have answered Finding 2, Finding 3 and Finding 4. So a lot of times it will just say go back to a previous finding within this, the finding that we're currently in, the procedure that we're currently in.

All this is doing is directing you as to where this particular finding is going to be answered. Does that make sense?

MS. MUNN: Yes.

MS. BEHLING (by Telephone): Okay, I didn't mean to make a long story out of that.

MS. MUNN: That's quite all right.

Before we go any further though, we tripped merrily over page five when we were discussing again the possibility of adding one more status possibility. I would prefer not to defer that. I would like very much for the work group to make their decision about that and a recommendation. And my recommendation would be that we accept your suggestion of open-imported. Does anyone have any problem with that?

Mark, does that do what you and I have been concerned about with respect to tracking from your sub-group to here?

MR. GRIFFON (by Telephone): Yes, I think that will work, Wanda.

MS. MUNN: Do you have any grief with that? Any comment to make?

MR. GRIFFON (by Telephone): No, not at all. No, I like that idea.

MS. BEHLING (by Telephone): Okay, I'll mark it down and Don will work on that.

MR. HINNEFELD: This is Stu Hinnefeld. Just remind me real quickly what would that pertain to?

MS. MUNN: We're specifically concerned with issues that are transferred into this work group, into our purview, from other subcommittees or other work groups who are dealing with specific issues, and they say, no, we don't need to deal with them here because Procedure xxxx deals with that.

DR. MAURO: That would be in the other one, not in this one.

MR. HINNEFELD: This would be findings that were not made in a review of the procedure at all.

MS. MUNN: Correct.

MR. HINNEFELD: There's no particular

findings in the procedure review that specifically ties to the DR issue.

MS. MUNN: Correct.

MR. HINNEFELD: But the DR work group thinks it's best addressed by, it's a procedure issue and so that, okay.

MS. MUNN: The subcommittee is saying this is no longer going to be an issue for us to be concerned with because it's being dealt with in this procedure.

DR. MAURO: Does that affect this stuff? In other words the mechanics, it seems to me that would, you just described will affect the Dose Reconstruction matrix where you would click and then come here.

MS. BEHLING (by Telephone): It will. There'll be a link.

MR. MARSCHKE: If we had a finding, if we already had an existing finding in the procedures that they're specifically transferring it to, then it would not affect it. However, if they basically in the other work group they say this has not been a finding in the procedures, but it should be a finding in the procedures, then this would be

a new finding in the Procedures working group or in the Procedures database that is coming from outside of our review of that, of the SC&A review of that procedure. So that's what I interpret this to mean.

DR. MAURO: This is a new nuance though that we didn't talk about before. So when during the dialogue at the DR under Mark, Dose Reconstruction, if something emerges during the review of a particular case that says, gee, this sounds like a pretty generic issue and needs to be addressed in a procedure because it's cross-cutting, that might open up a new finding you're saying that would have to, even though it may not be a finding in whatever the procedure is right now. That would actually create a new finding.

MS. MUNN: It could create a new finding. Traditionally what we have found --

Correct me if I'm wrong, Mark.

-- what we have found in the past is you encounter issues that already exist as findings in the procedures that are being addressed here. Traditionally that's what we've encountered. But it's very easy for me

to foresee the possibility of an issue arising when we're discussing a DR which would require a new finding under an existing procedure here.

Am I right, Mark?

(no response)

MS. MUNN: We lost Mark. I therefore assume that I'm right.

MS. BEHLING (by Telephone): I do think you're right, Wanda. I agree with you.

MS. MUNN: Very good.

MS. BEHLING (by Telephone): That was my intent here. There would be, in fact, I believe there are quite a few issues. And there would also be quite a few issues that again we're projecting ahead. We haven't gone down this path or even discussed whether the Site Profile work group would want to do this. But if they determine they want a database also, there would be a lot of linkage in between all of these databases.

And there are oftentimes, you know, on dose reconstruction reviews that we say this is an issue that really needs to be discussed in the site profile. I can think of several

issues like at Y-12 and identification of buildings and what buildings that we have neutron exposures and that type of thing.

But we will create a new finding in whatever database is appropriate, and it would initially get this open-imported, and then it would be ultimately when we have several tracking databases out there, it just might say open-imported from the DR review process or from the site profile review process, that type of thing, so we could track it back to that database.

And if you went to it, there would also be a finding in that database that sends it here. So there will be this linkage, and you'll be able to go back and forth and recreate how this came into this system and where it was generated from.

MS. MUNN: I would foresee that you would have a drop-down window the way you do on page seven with the address in finding which would clearly point to where it came from or where it went to.

MS. BEHLING (by Telephone): Exactly, that's what I envision also.

MS. MUNN: This is no small matter, and as a matter of fact, it has loomed heavily in my consciousness for a number of months as to how we're going to maintain any sense of what happened to that issue if it goes away from the original group that's working on it. Further, I anticipate that this process is going to be so effective that ultimately I would anticipate we will have multiple matrices.

MS. BEHLING (by Telephone): That's what I would anticipate also.

And, Don, again, have I said anything that you don't think is doable?

MR. LOOMIS (by Telephone): Oh, no, this is all doable.

MS. MUNN: Very good. A great relief, thank you so much.

Now we're back to your presentation, Kathy.

MS. BEHLING (by Telephone): Yes, I think are we ready to move on to page eight?

MS. MUNN: Yes.

MS. BEHLING (by Telephone): And page eight is a sort/filter screen, and we've discussed

this before. We really have not made any changes here, but let me just explain what is going on on this particular screen because this will be important to you.

On the left-hand side of the screen is your source level, and first, second and third are simply sorting tiers. It has nothing to do with our first set, or second set or third set or anything like that. These are tiers of sorting. You have a radial button -- and this is not a good example. Let’s assume that I’m working with the entire database, and I want to produce a report, a summary report, that where the procedure number, it’s sorted first by the procedure number. That’s why there’s a black dot inside that radial button under First.

A second tier sort would be the finding dates because that will tell me did it come from the first set, the second set, the third set. And then lastly, it would be sorted by are they open issues. All the open issues would be grouped together. All the closed issues would be grouped together. So the left side of this screen is simply how

you're going to sort the results.

The right side of the screen is a filter. If we don't want to look at all 472 records that are in there, and we simply want to look at, as in the example I provided, just the findings associated with ORAU PROC-0092, that's what this sort will do for you based on what I have in here. It's going to show you all of the findings because I have a checkmark in each one of the status boxes. So it will show you all the findings associated with PROC-0092.

Now if I uncheck all the boxes and only obviously put a checkmark in the open items, the filter would look at only PROC-0092 and open items associated with PROC-0092. It would first give us a summary report of how many findings those were, and then you could generate a detailed list behind that.

The one thing I did skip is the first line. That was the request that we are able to go into the various fields and sort by a word or by a specific word or a phrase. We've had several types of findings that may have to do with inhalation and particle size or

whatever. We can put in a specific word or phrase in here, and it will go into the details list and look at all of the fields and pull those particular findings where the word exists, or phrase.

And again, if we go down, you see underneath the procedure number you can select by finding date. The finding date, again, the reason I chose finding date is because it groups all of our findings together by when we submitted our report such as January 17th, 2005. All of our findings that were submitted for the first set of procedure reviews are dated 1/17/2005. So therefore, if I will put in that date and filter the database on just that date, I would get only those findings associated with the first set of, from our first set of procedure reviews.

MS. MUNN: Excellent.

MS. BEHLING (by Telephone): And again is a weighting again based on how we rate a particular item, you know, a five being a good rating, a one being a not very good rating. And if we want to either look at just those findings or sort when we go to do a matrix, if

we want to sort on that rating, we can say, okay, let's address the most critical items or those items that have the worst rating first. And so that gives us that option.

MS. MUNN: We had in the past. That's a logical thing for us to assume would occur again in the future.

MS. BEHLING (by Telephone): Right. And then lastly, it's just Don added this updated on or after to say that if you want to see just information that was updated in the database because of something that Steve or I did as of a certain date and say, okay, here are the updates that you made to the database as of this date. This particular filter gives you that option to do that.

Now, as you look at the screen, and you've seen all of this before. Does anyone have anything else that they can think of? And again, what will happen maybe as you start working with the database more, and I know from myself, that when you start adding filters, and you start looking at things and playing with them a little bit more, you say, oh, I wish I could do this. I wish I could do

that. I don't know that anyone has any ideas right now. Is there anything else that you feel would, that you'd like to see that is not here?

We can modify this particular screen and modify these filters. And again, I would suggest, I'm hoping that this is pretty close to a final version of this database, but as you work with the database if there are any suggestions, maybe it's something that the work group can discuss. And we can certainly incorporate them in as you feel is necessary.

MS. MUNN: If it develops that we have an overwhelming number of imported items, there's a possibility that we might want to add that to the filter, but I wouldn't at this point. Open would appear to be adequate right now.

MS. BEHLING (by Telephone): Okay, I agree with you. I think that's a very good idea. We may want to add an imported.

MS. MUNN: But that will take us a year to figure that out. Not this month.

MS. BEHLING (by Telephone): Do you have any questions on the sort/filter screen?

MS. MUNN: Paul has a question.

DR. ZIEMER: I agree with Wanda there because we've covered, you're filtering for everything else that's on that box, and you're going to add the filter, so you might as well --

MR. MARSCHKE: Yeah, that makes good sense to add into it --

MS. BEHLING (by Telephone): Yes.

DR. ZIEMER: The other way to do it is you leave these here and you filter them out, and what's left is what's ^ which accomplishes the same thing.

MS. BEHLING (by Telephone): I agree. I think that we should add the imported.

MR. MARSCHKE: If we're going to add another status, we should be able to sort on that or filter on the statuses we have.

MS. BEHLING (by Telephone): Okay, and as you can see on the screen that we're looking at currently on page eight, I am filtering on PROC-0092, and so page nine gives you the results of that filter. And it shows you that within PROC-0092 there were eight findings. And it identifies they did a finding that tells you the current status of the findings.

You can also see here on the top in red “filter is on”. And this indicates that you’re not looking at the complete database, and you have obviously filtered. You’re looking at a select portion of the database.

Now we select at this point the print summary that’s up on the top right-hand portion of the screen. What we’ll get is what you see printed here on page ten of my handout.

DR. ZIEMER: How do we know you’re filtering on PROC-0092? I know they’re all 92s, but how do we know you’re not filtering on the date which is all 9/20? Where does it identify the specific filter? Did I miss?

MR. MARSCHKE: This screen does not I don’t believe.

MR. LOOMIS (by Telephone): If you read -- this is Don -- if you read at the filter/sort data, it shows you --

MR. MARSCHKE: The previous screen pops back up?

MR. LOOMIS (by Telephone): Yes.

MS. MUNN: I just need the previous screen to verify.

MS. BEHLING (by Telephone): But you are correct. This particular filter could have been done in one of two ways. We could have selected the finding date. And again, I was apologizing to Wanda because of just the amount of data that I sent to her in preparation for this meeting. And I don't anticipate it being this overwhelming in the future because now -- and one of the things I wanted to hand out was the third set findings. So we will be looking at an entire huge group of findings as opposed to -- hold on one second and let me grab my other phone.

Am I still on?

MS. MUNN: Yes, you are. We're on page nine. We're talking about filters.

MS. BEHLING (by Telephone): This became a bit cumbersome just because of the fact that we were authorized to review some other procedures and independent. And so we had these individual procedures out there like PROC-0092 and PROC-0097 and OTIB-0052 that have, we submitted a separate report and you have separate dates.

So in this particular case when you

can sort either by the procedure number or by the finding date, and so it is a little bit confusing to determine what you're sorting on. But as Don indicated, if you select the sort button you can go back and determine what this filter represents.

MR. MARSCHKE: Kathy, I have a question.

MS. BEHLING (by Telephone): Okay, we were --

DR. BRANCHE: Kathy, you have a question.

MS. BEHLING (by Telephone): -- we were on page ten --

MS. MUNN: Hold on just a moment.

MS. BEHLING (by Telephone): Okay.

MR. MARSCHKE: Kathy, I have a question. On page eight you basically have a sort on, you're sorting on a status, the third level of your sort is on the status. On page nine it doesn't appear that the status has been sorted correctly. You have in abeyance, and then you open, and then you have in abeyance.

MR. LOOMIS (by Telephone): This is Don. The filter and sort actually only, the sorting portion is only being applied to the printout, if you hit the print summary or print detail.

On the screen it's always by procedure number and finding number and date.

MR. MARSCHKE: Okay, so the screen does not, the summary screen does not effectively reflect the sort.

MR. LOOMIS (by Telephone): We can make that clear on the filter/sort screen that we're only applying that to the printout.

MR. MARSCHKE: It only applies to the printout.

MR. LOOMIS (by Telephone): Yes.

MS. BEHLING (by Telephone): Does everyone understand what the question was and what's Don answer was? Because our second -- and again, correct me if I'm wrong here -- but because our second level sort is finding -- no, I'm wrong here, finding date. I was thinking it was finding number. But what Don is saying is, and I felt, too, it was important that we keep our finding numbers sequential.

MS. MUNN: Yes, it is.

MS. BEHLING (by Telephone): Go ahead, Don.

MS. MUNN: No, I was just commenting. This is Wanda. I was saying, yes, it is important

that we keep them numerically.

MS. BEHLING (by Telephone): Yeah, I felt that was more important than changing the status.

Okay, are we all right with that then? Do we need to make any change there?

MS. MUNN: I think we're okay.

MS. BEHLING (by Telephone): Okay, everybody's satisfied with that. Again, page ten is just our summary results. This is page one of two pages. And again, as I indicated earlier, the last column here is still procedure title. We did not put in this summary the name it shows on the summary screen in the database the finding description. We placed the procedure title listed in here along with the procedure number and the finding number.

So this is considered what we initially developed ^ report. And then behind this report would be each individual page for these -- did we say how many findings there were here? Forty-eight findings associated with PROC-0092.

Now in going on to page 11 what I

wanted to show you here is this is how you will actually generate a document to print while you're on the term server. And what you do on this particular screen, you go to the far left-hand corner where you see file, and you'll select file. And that will produce a drop-down box, and you'll select print. And when you do that it opens up this print screen that you see in the middle of page 11.

And you will select under the name the Adobe PDF File. It will now allow you to save that file, and I assume everybody has a U drive. And just as you would do it in your document, you could save this particular output to, you would name it and save it to your U drive. And you could then download it with your secure FX and print it from your computer.

Everybody okay with that?

MS. MUNN: Yeah, good.

MS. BEHLING (by Telephone): And then finally, I guess once again shows you the results of the very first page of your detail screen. And as you can see, this was the lengthy one where you, both the findings, and

NIOSH responded to each one of these findings so try to keep everything for one ^ for each detail or each finding on one page. That's how we designed the database.

So that's it in a nutshell, and if you have any questions or comments or changes, let us know.

MS. MUNN: Kathy, I thank all of you who had anything to do with this. You just really and truly need to be applauded for an excellent job. The amount of detail is overwhelming, and to have gotten this far with having the entire database populated is from my point of view extraordinary, and we thank you.

MS. BEHLING (by Telephone): Thank you. I think this is going to be a very useful database and especially as we talk so often, there was always a question in everyone's mind how are we going to ensure the findings don't fall through the crack, and that we can link what's happening in one work group to another work group and not lose track of a specific finding. And I think this gives us the means of doing that.

But as we've always talked about

having an archive of each and every finding from cradle-to-grave, from initiation-to-resolution. So hopefully, and as I said if after you work with the database we find that there's a more efficient way to do it or something you want added or some report or results screen that you would like to see, I'm sure that we can do that.

MS. MUNN: Certainly with the addition that we've discussed making today, what I see at this juncture covers all of the major issues that were of serious concern to me as to how we were going to address this. And I think this is true of the other members of the work group as well.

Thank you again, I don't think there's any need for us to go through any of the other additional materials that you sent unless someone specifically wants to discuss one or more of those. I'm a little concerned that as a work group we've had to focus so strongly on what's happening here that many of the issues themselves are getting short shrift.

But I don't think there's any way we could avoid that in order to shift gears as

seriously as we are here and cover all the bases as you have done. It required all of our efforts to see that that happens first before we can get back to the serious issue of addressing each of the issues other than the ones that I have incorporated on the agenda.

Thank you very much, Kathy, and all of you.

MS. BEHLING (by Telephone): Oh, you're welcome.

MS. MUNN: In view of the fact that it is 11:30, and we have not bothered to take a coffee break even, much less a comfort break, it seems to me that this would be an appropriate time for us to break for a 45-minute or an hour lunch rather than starting some other items and coming back. What's the feeling of the group? Is this a good time for the break?

DR. ZIEMER: One question before the break, I'll ask Madame Chairman and also ask Dr. Branche, are we on schedule to have Kathy present a summary of this at our next Board meeting?

DR. BRANCHE: Yes, actually the first day of

the Board.

DR. ZIEMER: Okay, and Kathy, you're aware of that?

DR. BRANCHE: She knows that.

MS. BEHLING (by Telephone): Yes, I am. And what I want to do during the presentation is actually do a hands-on type of thing. I will generate something like you're looking at today so that we could go through page-by-page. It would be nice if I could actually have the database online and something that I can click on. When we're on the summary screen I could click on a field and have data open up at the detail page and show you a hands-on version of the database. I'm hoping that we'll have the, be ready to do that. If not, we'll go through something very similar to what --

DR. ZIEMER: An interactive presentation.

DR. BRANCHE: Kathy, this is Christine. I think you're having backup, being prepared for a backup presentation as you just expressed is appropriate. But based on everything you've told me, my coordination with Zaida Burgos is that we've coordinated with the hotel that

will allow you to be able to in real-time give a presentation from your laptop and via the large screen provided in the room.

MS. BEHLING (by Telephone): Okay, very good.

DR. BRANCHE: So if there are any particulars, any specifics that you need that you think you can send us in advance that will allow us to expedite your access to it, please send that ahead of time, but based on everything you've told me, I think we're set. It's just a matter of the hotel holding up their end of the deal so pretty much.

MS. BEHLING (by Telephone): Very good. One other question now that I do have with regard to everything that you've seen today, Liz and Emily and Larry. Would there be any problem with me making this presentation at the meeting?

MS. HOWELL: I mean, I'll go through the slides again. I didn't see any personal identifiers on the ones.

MS. HOMOKI-TITUS (by Telephone): I was going to say I think Nancy sent me this presentation to look through. And I looked

through it the same as Emily did. It's a little tough to see some of the information on the screen. I don't know, maybe it's bigger there looking at it. I would agree with Emily. I don't think there's any personal identifiers that would need to come out. And I think I've already cleared this with Nancy.

MS. BEHLING (by Telephone): Okay. And if you'd like I can certainly send my presentation for the Board meeting to you prior to that Board meeting.

MS. HOMOKI-TITUS (by Telephone): That would be great. All we would be looking for is if you accidentally had somebody's name or something.

MS. BEHLING (by Telephone): Okay.

MS. HOWELL: And since it's procedures, it's unlikely, I mean, if you could, please do send us your presentation, but I'd be more concerned if this presentation was for another working group.

MS. HOMOKI-TITUS (by Telephone): If it was from a subcommittee or something where there might be a claimant's claim number again in the name of a document, then it might be a

problem.

MS. BEHLING (by Telephone): Okay, very good. Thank you.

MS. MUNN: That being the case one last thing before we break for lunch, does anyone have any additional items that they wish to add, change or delete from the agenda?

DR. BRANCHE: Today's agenda.

MS. MUNN: Today's agenda?

(no response)

MS. MUNN: If not, we'll assume we will try to cover the items mentioned.

MR. MARSCHKE: Do you want to talk about this draft letter to HHS?

MS. MUNN: We do want to talk about the draft letter to HHS, and I don't know whether everyone has that or not. We may need to send that to everybody on their e-mail so you'll have it on your screen at least.

MR. ELLIOTT: Was it in one of the files that you've sent yesterday?

MS. MUNN: Yes, yes.

DR. BRANCHE: I thought we established that there wasn't going to be a draft letter to HHS when I asked you about that. Let's ask this

again.

MS. MUNN: All right.

DR. BRANCHE: This is a letter you're suggesting is going to go to HHS.

MR. ELLIOTT: This isn't a letter.

DR. BRANCHE: But it isn't a letter.

MS. MUNN: No, no. This is the draft report that SC&A has put together which the discussion needs to be is this the kind of report that needs to go to the letter to the Secretary explaining to him what this change in the database is and how it now is going to affect us. That's the question.

DR. BRANCHE: Okay, well, I'm --

DR. MAURO: Let me help out a little bit. I believe the intent of this draft report was it was our understanding that periodically you report back to HHS on the various tasks such as we do with Task Four where the dose reconstruction part is summarized, and I know that Mark is looking at it.

The intent of this was to be the equivalent of that to report to HHS on the status of close out of the various issues in the first set of 30 procedures that we

reviewed or we basically opened up for consideration by the working group because this would be something they want to look at as one way to communicate to HHS how we manage to complete our work, the Board has managed to complete its work regarding the review of the first set of 30 procedures that were reviewed. And so that was the intent. That is, this is the kind of information we wanted to report to HHS on that.

MS. MUNN: And it's difficult to convey that significant information being provided.

DR. BRANCHE: What I'll do is at the lunch break I'll confer with the attorneys to make certain that given what your intention is, is it appropriate that this report go to the Board Chair, the Board and the Board Chair. And then they make that a part of their report overall. So let me just get that information, and when we open up our discussion after lunch, I'll get back to you on that.

MS. MUNN: It was my expectation that this go to the full Board with a recommendation from the group.

DR. BRANCHE: Okay, thank you. Thank you.

MS. MUNN: We are in abeyance until 12:40.

DR. BRANCHE: Twelve-forty eastern daylight time, and I'm closing off the line, and I'll reopen in one hour.

MS. MUNN: Thank you all. See you in an hour.

(Whereupon, a lunch break was taken from 11:40 p.m. until 12:40 p.m.)

DR. BRANCHE: This is Dr. Christine Branche from NIOSH, and we're going to start again on the Procedures work group meeting with Ms. Munn as the Chair. And again, I ask if anyone who's participating by phone, if you would please mute your phone during our deliberations. And if you do not have a mute button, then please use star six. And then you can use that same star six to unmute when you are ready to speak. Thank you so much.

Ms. Munn.

MS. MUNN: If you have your agenda in front of you, I think what we'd like to do if it's agreeable with all concerned, is to go ahead and go down that agenda in order that we have it and postpone our discussion with respect to our conversation earlier about the SC&A paper

on whether or not that's going to be too much information to be transmitting to the Secretary until toward the end of the session when we're going to have John Mauro holding forth on another issue. We'll just try to pull that in at the same time.

I gather from your comment, Christine, that you had had some conversation about that over the lunch hour that would it be better to address now?

DR. BRANCHE: As you wish, we can do it later as you requested.

MS. MUNN: Well, if you've had some discussion about it, let's go ahead and discuss it now.

DR. BRANCHE: Given that the Procedures work group is working under the banner of the Advisory Committee, I think it would be most prudent for this work group to provide their report to the Board. And if there's consensus on what you all have put in your presentation to the Board, then they'll be part of the transcripts from that meeting.

And then when Dr. Ziemer does a write-up of that meeting or any of the information

that comes from this Procedures work group, then he can include that and as always is at liberty to include a copy of the report or elements of that report to the Secretary. But I think an outright letter or cover note or information directly to the Secretary from this work group would not be appropriate. I think it would need to go to the Advisory Board, and then you could -- Dr. Ziemer, include comments as you see fit.

DR. ZIEMER: Well, that's correct. Nothing goes to the Secretary unless the Board approves it anyway.

MS. MUNN: We had never anticipated that that would be the case.

DR. BRANCHE: And I even think that even the report as SC&A has drafted it and you and the work group amend it, it would only be appropriate for the Secretary to see portions or specific comments that you think are germane for other deliberations that the Board would want to have as messages to the Secretary.

DR. ZIEMER: As I said, whatever goes to the Secretary has to be approved by the full Board

as an official transmittal and an official recommendation.

MS. MUNN: And as always our intent, at least it was always my intent, and I think, SC&A's, to have us debate the issue of how much is too much to submit to the Board more than anything else. And that's going to be a bit of a thorny issue I think, but we will address it later once we get to John's presentation probably about two o'clock.

NIOSH: RESPONSE TO OTIB-0017 SC&A WHITE PAPER

First item on the agenda, NIOSH response to OTIB-0017, SC&A's white paper.

MR. HINNEFELD: Stu Hinnefeld, we have some draft responses which I've not distributed to the Board or SC&A. I think we want to have a little editing on our side before we provide them and also, well, certainly we want to do that. And we'll provide them to the entire working group and to SC&A well in advance of a meeting.

I would like to go through kind of the basics of the SC&A report and make sure I have a good understanding of the point that's being made so our response hits on that issue.

The first, well, we've just kind of broken it into a few topics, the first having to do, I believe, with essentially a geometry question. Now, to refresh everybody's memory, OTIB-0017 relates to the interpretation of dosimetry data for assignment of shallow dose. So it's a shallow dose OTIB. The first comment from SC&A --

MS. MUNN: Excuse me. Would it be helpful for us to have the white paper up as it's being discussed?

MR. HINNEFELD: Well, if you have the SC&A white paper. I did not bring it. If you have it, it might be --

DR. ZIEMER: What's the title and date of the paper?

MS. MUNN: I think the date is probably 11/12/07.

DR. ANIGSTEIN (by Telephone): This is Bob Anigstein. The paper, in the heading it says prepared by SC&A, November 9th, 2007.

MS. MUNN: And so it says OTIB-0017 --

DR. ANIGSTEIN (by Telephone): I would say, I don't know if it would be practical to, I could e-mail it right now, but I don't know if

that would do any good.

MS. MUNN: No, I don't think that's necessary, Bob. It was just an idle thought on my part. I always like to see what I'm, what is being responded to.

DR. ZIEMER: Well, what's the exact title of the file?

DR. ANIGSTEIN (by Telephone): Good question.

MR. HINNEFELD: On my document on my system it's stored as OTIB-0017 Issues-dot-doc.

DR. ZIEMER: Is it a Word document?

MR. HINNEFELD: It's a Word document and starts with OTIB-0017.

DR. ANIGSTEIN (by Telephone): That is correct. That is exactly what I have.

MS. MUNN: And here's the title of it.

DR. ANIGSTEIN (by Telephone): The actual title of the printed title is "Open Issues Regarding-quote-Interpretation of Dosimetry Data for Assignment of Shallow Dose-unquote, ORAU OTIB-0017, Revision 01."

MS. MUNN: Go ahead, Stu. I'm sorry. I didn't mean to --

MR. HINNEFELD: I will essentially

paraphrase in broad terms the various issues raised in the white paper and then maybe have a brief discussion about it.

The first issue as I read it or as we interpret it is a comment on geometry dependence and how it may be, I think, more acute with a shallow dosimeter than with a photon dosimeter and our procedure for the OTIB not being sufficiently expansive in addressing that characteristic of shallow dose and shallow dose dosimetry.

And I guess in our position as we made it as our response in a number of these findings in this venue and others, the areas, looking at a procedure by itself will not necessarily capture all the information provided to dose reconstructors on a particular aspect, in this case concerns about the geometry of shallow dose.

And so we will provide a formal response, a more fleshed-out response, but I think that one thing to remember here is that while a specific procedure may be, it may not describe all the things you have to worry about in a particular issue, there’s other

guidance that the dose reconstructors use every day and consult and are briefed on at staff meetings to discuss all those issues that go into this.

And certainly when there's a geometry concern with a particular job title or work environment, we do expect our dose reconstructions to reflect those kinds of aspects as well in this extent and to the extent that if there were a situation where you would have a significant geometry concern about a person's exposure orientation versus how the badge was, how the badge would be irradiated in the exposure location, then we would expect adjustment appropriate to that.

So like I said we don't deny that there is a particular geometry dependence in this case, but we're not so confident that we can address everything in one procedure and that this procedure should be taken in the context of all the other guidances provided to the dose reconstructor.

MS. MUNN: So that essentially will be your response to --

MR. HINNEFELD: Something like that at

least. See, I can always be overruled. I'm the guy who shuffles the paper, and Jim does the heavy lifting so I can always be overruled.

Now the second issue as I interpreted is essentially a hot particle issue. And how to address a case where -- I understand the point that's being made. If a person were in an environment where hot particles were a potential -- and I think we can probably reach some agreement on what those environments would be. I don't plan to do it today, but I don't think there'd be a lot of disagreement on the kind of environments where there might actually be a hot particle -- and then develops a skin cancer and claims for a skin cancer, how do you account for this potential for hot particle exposure in a skin cancer?

And so in thinking about that, and I believe the suggestion is that in those situations if a person felt a skin cancer on an exposed part of their skin should be, I guess, face, neck, and maybe arms although I would argue arms. I might argue that in terms of whether that's really allowed to be exposed

in that kind of environment. So someone who develops a skin cancer shouldn't be just assumed that there's a hot particle exposure at the site of that skin cancer and proceed accordingly.

And we have not done that to date. Whenever we have evidence of a skin contamination of any sort, hot particle or other, we do, in fact, do dosimetry for that skin contamination if it's a, it's only relevant, if it's a skin cancer. But absent evidence of a contamination event, in particular a hot particle contamination event which is where there might be a really official^ skin dose, we don't. We don't necessarily assume that that spot where that skin cancer developed was contaminated by a hot particle.

If you start down that path, I don't know where you stop in terms of from the dosimetry standpoint. For instance, if you're going to assume a hot particle contamination at that site, why only one? Why not? If one hot particle scenario that you put together doesn't arrive at a POC above 50 percent, then

why not assume another? Because you have just as much evidence for the second as you have for the first.

And then the second element about the dosimetry in this is what kind of assumptions do you make about residence time of the hot particle, you know, just based on, and do you base it on personal hygiene? Because eventually they'll take a shower, he or she will take a shower, and there will at least be some removal during that time. And do you base it upon, you know, what do you base it on?

And so our approach has been absent, you know, the absent evidence of some sort of skin contamination event, we don't necessarily assume that the site of the skin cancer was contaminated in part because I don't know how to quantify, if you made that assumption, how do you quantify it? So that, our response, I think, will be along those lines. But like I said, we'll have a more developed response later on and probably any kind of additional discussion might be better served at that time.

MS. MUNN: Probably. I see they recommended a course on statistics should be utilized to calculate the probability of occurrences in their opinion. But we'll look forward to your addressing that in the response.

MR. HINNEFELD: And then the --

DR. MAURO: I just wanted to -- coincidentally, we're in the process of doing blind dose reconstruction right now. And coincidentally, it turns out the person that worked at Portsmouth, and he had five independent cancers, skin cancers on his ear, neck and ^, and we're reconstructing, doing a blind dose reconstruction.

And what we have, and I think it plays toward this -- it's something to think about as a real problem. And this person always wore a film badge. So there's certainly plenty of data on what the exposure to open window was in distance. So this person was in a beta field of any sort, close to, say, a uranium source. And one of the things we're concerned about is did he have a hands-on role in this. We're talking about UF-6, and he was out there. He worked with these gloves, but

he didn't have a hood on. So I'm envisioning, you know, ^ dust ^. And I could see this guy scratching his neck. And so I'm in a dilemma. Here I am doing a blind dose reconstruction, and I realize you can't say anything about it, because maybe they did calculate it and maybe they didn't.

But I asked myself -- I'm doing the work --, I said, well, what am I going to do? Here's a guy that's got five independent skin cancers on his neck and his jaw. And if I go ahead and just reconstruct his dose based on a film badge ^ anything. But then I said, but I could see the crease of your neck, we know he did a lot of work in the Marshall Islands ^.

DR. ZIEMER: Who was he working with?

DR. MAURO: USFC^.

DR. ZIEMER: Natural uranium?

DR. MAURO: It turns out, well, he, it's natural uranium except we have data on the, bioassay data, also because he also had an internal cancer. The data, both fluorometric and alpha, and the concentrations, and it appears that it's really close to natural. Even though he worked in one of the buildings,

but he did work with enriched uranium, so we get into his job description said he very well could have been exposed to some intermediate level enrichment, but his bioassay data says no.

So what we did was say, okay, what would be the dose rate if we had some data on -- strangely enough, EPA has a whole report on milligrams per centimeter squared. If you're in a dusty environment, how much soot accumulates on your skin? It turns out it's 0.05 milligrams per centimeter squared. It's a good number.

And so what we did is we said, okay, let's assume that this guy had 0.05 milligrams per centimeter squared of natural uranium on his skin. What would his millirem per hour be to his skin? And it turns out, and here's the whole problem. Okay, we can give you the millirem per hour but how many hours?

I mean, so we're struggling with this same problem on a blind dose reconstruction, but I think it's a real problem. Because I think, I don't think it's so absurd to think there's a scenario where a person working in

at Portsmouth could very well have gotten some uranium contamination on his face and neck especially if he wasn't wearing, he had no respiratory protection. He's not wearing a hood. But he did shower every day.

DR. ZIEMER: But, you know, the hot particle problem is ^.

DR. MAURO: I understand that.

DR. ZIEMER: It's very high specific activity, discrete particles. You're talking about skin contamination --

DR. MAURO: The dose rate is 20 millirem per hour.

DR. ZIEMER: That's low compared to a hot particle.

DR. MAURO: Oh, I agree with you. I agree with you. But even under the circumstances I just described, I think it's an issue. Now the hot particle kicks it up even more because the dose rates can be very high.

MS. MUNN: Both interesting and maybe serendipitous for us that the two are taking place at the same time. It might be helpful for the two of you to talk about offline.

DR. ZIEMER: But don't help him with the

blind --

MS. MUNN: No, no, no, but talk about the best, real-world, claimant-favorable approach to how to do this and that's --

DR. ZIEMER: See, a true hot particle thing you can get really high doses in a time that would be less than between showers.

MS. MUNN: In a very short time.

DR. ZIEMER: Right, but the likelihood of getting that with natural uranium between showers is, I can tell you intuitively, it's got to be awfully low.

DR. MAURO: It turns out it's a lot more than what you get from reconstructing his dose from his film badge.

DR. ZIEMER: Right. But put in the context of dose limits to skin which are much higher than anybody --

MR. HINNEFELD: We have a response that we owe that's not been provided. I'm talking here in generalities from drafts. So we owe a response, and so after that response is shared with the working group and SC&A, if you would like, we could have that discussion at that point about this finding. We won't talk about

the --

MS. MUNN: No, I'm thinking it might be helpful for your purposes to have your response in hand and share it with SC&A. But then we'll look forward to next where we, right now we don't have another meeting scheduled until after -- at the end of the day we're going to schedule a meeting for this work group after Tampa.

And I'm assuming that anything we're talking about here is not going to be resolved prior to the Tampa meeting anyway because we're not going to meet again. So can we say at our next meeting that we can expect, we carried this one forward, I think, from our preceding --

MR. HINNEFELD: Yeah, I think so.

MS. MUNN: -- meeting with the expectation we'd have that ready by now. But we know how things go, so at our next meeting we'll have all of these OTIB-0017 issue responses in hand? Okay?

MR. HINNEFELD: It's my expectation that we'll have our response to this white paper available probably before the Tampa meeting so

people have it in time to work with it before.

MS. MUNN: All right.

DR. MAURO: Another facet to this is this issue has come up at the Nevada Test Site, and it's an important issue. And the position that you folks take, at least in the case of some of the workers at the Nevada Test Site, is before they would enter a forward area. And there's very strict controls. A person would completely suit up and be protected. And in those, a position, I believe, was taken from one of our meetings was that that scenario ^.

That is, this person is, he can know that the airborne contaminants were there and the potential for that kind of contamination was there; therefore, in that scenario, he could have a ^. So there may turn out there may be certain sites and certain settings where it is a real issue and places where it's precluded.

MS. MUNN: It's just simply not feasible which is true.

MR. HINNEFELD: And then a final topic that really warrants a response, I mean, there was

a discussion here where there was sort of agreement with our position and state their place having to do with thicknesses of covering materials and how much a beta dose would be attenuated by clothing, for instance, that people wore, had some responses there as well. I won't get into those, but there are various references and various sources that can be cited for thicknesses of coveralls and cotton, et cetera, et cetera. So I guess there'll be additional discussion in our response paper.

MS. MUNN: And you'll have specific responses to the characteristics that were given in the report?

MR. HINNEFELD: Correct.

MS. MUNN: We will say on the next agenda that we see for this group that we'll have full responses to all of the issues raised on OTIB-0017.

DR. MAURO: Wanda, is it correct to say that no action items at this time for SC&A?

MS. MUNN: No, no action items for SC&A.

NIOSH: OTIB 0019-10

NIOSH will verify the page change to

OTIB-0019, comparing parametric and non-parametric 95th percentile data effects. That page change has been made?

MR. HINNEFELD: No. We've had a, well, we've ^ and the problem is we turned this over to a statistician. So we're analyzing the existing datasets, you know, the datasets that we've used for these various coworker -- this came out of coworker studies. And when we use coworker distribution, our approach has been to use a parametric description of that distribution in order to establish essentially a geometric mean and standard deviation and so to define that sort of distribution.

The comment was that a non-parametric, in other words, rank-ordered distribution, to define the 95th percentile may, in fact, be more favorable in certain instances than parametric 95th percentile. And so in trying to deal with the actual implementation of that step, there was some discussion about, well, but is that really an appropriate thing. I mean, how can you use a non-parametric 95th percentile and then use a missed dose for a dose calculation that essentially assumes a

parametric distribution of the data?

And so we are comparing actually, for the, so far we've gone through the internal dosimetry dataset, coworker dataset, and we are doing a comparison non-parametric to parametric. According to Jim, he's of the opinion that what we're doing in using parametric distribution is either neutral or favorable. I don't know if it's in every case, but certainly overwhelmingly.

We've not yet applied this to the external dosimetry distributions and so there's more to be done with the statistician there. And we may yet get out a page change in 0019-10 to address things, or we may come back to the work group with some other approach or some other reason why we believe what we're doing is either neutral or favorable.

MS. MUNN: Is it likely that my statement here with respect to the review and report being ready before the St. Louis Board meeting feasible?

MR. HINNEFELD: That's June or July?

MS. MUNN: The St. Louis meeting is in June.

MR. HINNEFELD: Well, right now I think that still might be feasible. I think we'll know, if we're going to schedule another meeting of this work group after Tampa --

MS. MUNN: We will.

MR. HINNEFELD: -- we'll have a better idea at that point.

MS. MUNN: I had anticipated, we'll discuss it, of course, later, but I had anticipated near the end of May possibly?

MR. HINNEFELD: Yes. I think I don't see any particular problem.

NIOSH: REVIEW OF OTIB-0012

MS. MUNN: Report on review of OTIB-0012.

MR. HINNEFELD: This is actually a DCF finding that came under review of OTIB-0012, but it actually speaks to the dose conversion factors for external doses that are published in our IG-0001, Implementation Guide-0001. We have done some preliminary analysis of the information that SC&A's provided. I think there's certainly support for all points in their analysis that require a pretty careful response. We've developed a list of potential courses of action in order to respond.

One of the courses of action is no change with sufficient justification on why that's okay. And then there are other courses of action about what might be the appropriate way to adjust dose conversion factors with dose conversion factor tables if, in fact, no action cannot be sufficiently justified. So we are continuing to develop that and to try to work up our preferred position on what action is best for the program and is technically justifiable.

MS. MUNN: And timeline's near the end of May still feasible with that one?

MR. HINNEFELD: I think that should be okay as well. There's been a fair amount of work done on that already, and there's still some work to do. So I think that we're hopeful we can have something to your work group in advance of the May work group meeting.

NIOSH: PROC-0092

MS. MUNN: Good. Report on procedure language for PROC-0092.

MR. HINNEFELD: This is an ORAU procedure that is on conducting close-out interviews. We have the ORAU task manager who was

responsible for that activity has marked up PROC-0092 and has distributed it within ORAU for review, part of their internal process, and is now resolving internal ORAU. So we at OCAS have not yet seen the revised version. We may, in fact, have comments as well when we see it.

But I think late May would be, is a reasonable target for having a revision or some, I guess we may want to talk about how we may want to do this. We could revise PROC-0020 and issue it. We could revise PROC-0020, have a draft revision -- I'm sorry, PROC-0092 -- PROC-0092, we could prepare what we feel would be our preferred draft version of PROC-0092 and have additional discussion here at the work group about if there are recommendations we feel like we don't believe this warrants a change in the procedure and have discussions about that before we publish PROC-0092.

I don't know what the preference of the work group is in terms of that particular step. Or it could be that our revision incorporates every recommendation from the

Board, and there wouldn't be any need for that kind of step.

MS. MUNN: Memory fails me. I can't remember exactly how many outstanding items we had from one of the groups that she sent, and I am looking for it now. Do we have eight out there?

DR. ZIEMER: Some of them are kind of lumped together. I'm looking at the December 7th summary and there are really just two items showing. One lumped together Findings 4, 5, 16, 17 and 21 through 30. The other lumps together five, 17 through 19 and 30 through 35.

MS. MUNN: So that leaves us actually with only --

DR. ZIEMER: There's an initial response from NIOSH in both of those dated November 14th.

MS. MUNN: Yeah, that leaves us with --

DR. ZIEMER: And then what happens after that?

MS. MUNN: Well, we're looking at the new matrix gives us Procedures tracking system open items, leaves us with six after having

combined certain issues and resolved others.

DR. ZIEMER: Well, they're both showing as open.

MS. MUNN: My immediate response would be I'd like to see these open items closed before then we consider the possibility of re-issuing another --

DR. ZIEMER: It looks like there is a NIOSH response that we, we actually have that's dated November 14th?

MS. MUNN: It says, "All efforts are made during the final closing interviews to explain the dose reconstruction report and answer questions the claimant may have. OCAS believes this balance is currently being maintained and is appropriate, will be evaluated during the revision of the closing interview." So the question then becomes whether this is an acceptable response from SC&A.

MR. ELLIOTT: If you're looking at the version that was dated 3/6/2008, is that what we're looking at here? The open issues on PROC-0092?

MS. MUNN: I have 3/7/08.

MR. ELLIOTT: Well, yeah, at the top it says 3/7/08. At the bottom of mine it says 3/6. So the way I see this organized is it introduces SC&A's finding, and then it introduces NIOSH initial response. And then you have work group discussion on 11/7/2007. And those are the, I guess, summary outcomes of that discussion.

MS. MUNN: The final outcome is NIOSH needs to discuss appropriate wording with legal counsel regarding understanding DR and SC&A should revisit the issue and come back to NIOSH with suggestions of personalized wording.

DR. MAURO: I don't think we knew that.

DR. ZIEMER: So each page has another issue presented.

MS. MUNN: May I make a suggestion that both NIOSH and SC&A now work from the new matrix open issues which we believe -- I have not had an opportunity to cross-check whether the minutes of the meeting agree with what has been used to people by matrix, but let's work on the assumption that our comments were correctly captured and that these six open

items that are shown on the tracking system page are, in fact, appropriately recorded on the detail sheets and that the detail sheets will show you what we anticipate the next actions need to be. Is that acceptable to both --

MR. HINNEFELD: Yeah.

MS. MUNN: -- SC&A and NIOSH? Let's work from this and we will anticipate responses from both of you then at our next meeting. Acceptable?

MR. HINNEFELD: Yes.

MR. ELLIOTT: Yes, I think this captures the action items we both need to follow up.

DR. MAURO: I guess that would give us an opportunity to implement on this particular machine that we built.

MS. MUNN: It will also give us an opportunity to individually check what's on this document with our memory and our notes from the last meeting so that we can identify whether we are, in fact, on the right track. This will be our first test.

MR. MARSCHKE: Can I make note, with the open items that we set out, that we sent out

are, in fact, only the open items. There are two other items that are in abeyance that basically you should also probably be taking a look at. In Finding Number 1 and Finding Number 3 are in abeyance. Because if you look at Finding Number 5, it refers to be addressed in number one which is not included in this little packet that was sent out.

And Finding Number 6 refers to Finding Number 3 it says will be addressed in Finding Number 3 and that also was not included in the packet that was sent out. So you have to, this should be augmented with two additional.

DR. MAURO: If I recall, in abeyance means that a change in a document is in progress.

MS. MUNN: It's in progress.

DR. MAURO: That if that change is made in accordance with what we've already discussed and agreed to, will resolve the issue.

MS. MUNN: Correct, right.

DR. MAURO: So in effect, whenever there is a cross-reference back, for example in the guidance that Steve just described, they're effectively in abeyance waiting for numbers one and three --

MR. MARSCHKE: Correct.

DR. MAURO: -- to be taken care of. So in a way we really need to look at those packets. And right now this is only two. In other words when we look at what's in front of us right now, only issue number two is what I would say, yeah, we need to take some action at this time in terms of filling out this form because everything else there is in abeyance. So there really is no, I don't think there's any addition to be made other than trying to be responsive to the two directives that we've been given by you.

MS. MUNN: I think that's true and in abeyance items, if I remember, are in NIOSH's hands.

MR. HINNEFELD: Oh, yeah, it's our PROC-0092, and that's what we're going to revise, and we agreed that there are revisions in process. So with respect to personalizing the interviews which is where we ^ .

DR. MAURO: And we didn't give that to you. We owe it to you.

MR. HINNEFELD: -- I don't believe we have that yet so we can still work that into a

revision.

DR. MAURO: I guess an important point, and I think we've addressed this before, is that when an item is in abeyance, which means we're all in agreement and it's just a matter of it being implemented in the procedure, I guess from the point of view of this working group, does that make the item in effect closed or does that mean that, no, it doesn't really close until the change is made and the Board and the working group feels comfortable that, yes, the change that was made to the PROC does, in fact, meet the letter and intent of what we agreed to during the working group?

MS. MUNN: Originally, our agreement was the latter. That in abeyance means we've agreed what needs to go there. It hasn't gone there yet. So it does not close for us until it does go there. When it does go there, then it meets the criteria we've agreed to earlier, and then it becomes a closed item, hopefully. So that means we do need to keep track of our in abeyance items as well as our open items.

NIOSH: PROC-0090 MATRIX ITEMS

PROC-0090 matrix issues, provide a

summary for each box. We didn't get that I don't believe. If we did, I didn't see it.

MR. HINNEFELD: Well, this is taking the findings from the CATI interview process. Is that what we're talking about? I think PROC-0090 is the CATI interview. And those findings originally were on three other procedures, you know, numbered differently. Those three procedures were then consolidated in PROC-0090, but that consolidation didn't address the findings under procedures, and so our action was to essentially complete the findings matrix for PROC-0090 by copying those findings of those earlier procedures into PROC-0090.

And quite frankly, I haven't done that because I expected a new version of the ACCESS database. I thought why don't I just work from the new version because we're already going to have enough additional coordination time or making sure, you know, that I am not trying to write to it the same time somebody who uses ORAU is trying to write to it.

So I was anticipating getting a new matrix which is now up on, you know, the

ACCESS database which is now up on the O drive and running. But now, we'll go ahead and we'll do it. So we haven't done it now because we were waiting for the issue -- to essentially for it to be operating on the O drive.

MS. MUNN: I guess we'll have to rely on your discretion to identify whether the data that's being used for people, the matrix, is, in fact, what needs to be there.

MR. HINNEFELD: Well, I had just intended to copy the existing findings.

MR. MARSCHKE: I think we've already done that because SC&A's already taken from PROC-0004, -0005 and 0017, I believe it is, yeah, and taken all those findings and turned them into PROC-0090. So all those have been, so that part has already been done. In this 472 findings that was shown on Kathy's database includes not only the original findings in PROC-0004, 0005 and -0017, but also their mirror images in PROC-0090.

MS. MUNN: So those are transcribed verbatim.

MS. BEHLING (by Telephone): That's correct.

Excuse me, this is Kathy. Yes, I did try and do that in the database. I created a new PROC-0090 findings, and I added in the NIOSH follow up, the information that Stu had forwarded to all of us on, I think the date is December 11th, 2007. I incorporated his comments into the database. So as long as Stu, Stu can go in there and just verify that the information that I entered is appropriate, I think this has been completed.

DR. MAURO: Are these then items which we agree in principle here is the solution? Are these then sitting in the database as in abeyance?

MS. BEHLING (by Telephone): I have these right now as open items on PROC-0090 because none of the issues were resolved under PROC-0004, -0005 and -0017. So everything was transferred, all of the findings were transferred over to PROC-0090, and I actually have them classified as open because nothing was resolved. I know we've asked this question every time we have a meeting, but have we been authorized to review PROC-0090?

MS. MUNN: I didn't think so.

MS. BEHLING (by Telephone): Okay, then that's why they're open. And again, open means there's been no further discussion on these items under the PROC-0090 procedure, which I don't think there has. And if it's open-in progress that would mean that we have been given authorization to review that procedure, and we've started the issues resolution process. But that I didn't believe had happened yet for PROC-0090 so that's why the status in PROC-0090 says open only meaning it's on the database, but there's not been anything, we've had no discussion on these topics.

MS. MUNN: So what we're expecting at our next meeting is that all of these items will have been reviewed on the new matrix and from that we are likely to have discussion taking place in the work group as to whether or not these are adequate responses or whether additional action is necessary, right?

MS. BEHLING (by Telephone): That's what I would anticipate.

MS. MUNN: All right. Is this going to be at this obviously long work group meeting that

we're going to have in May?

MR. HINNEFELD: Well, I mean, it's going to be a discussion of information that's in place now. So we can certainly do this. And I think our practice has been, I think, to do that in the work group's fashion.

MS. MUNN: Right.

DR. MAURO: So really, let me just make sure what I'm hearing exactly. There are really two steps to the process. One is to move the issues out of the old place where it was, four, five and 17, move those issues into PROC-0090 where they should be, and that's where they now sit.

MS. MUNN: That's correct.

DR. MAURO: And the issues themselves as a substantive issue need to be addressed.

MS. MUNN: Correct.

DR. MAURO: And so the next step in the process is no action at SC&A's, but you folks have, what, put out a white paper or put out a --

MR. HINNEFELD: Well, there are responses. I guess to be honest, I need to go back and refresh my memory on the various responses and

things of that sort. I know there, it seems like there may be some actions we suggested we'd like to look into or certainly as that is feasible, those sort of things.

DR. MAURO: You're doing --

MR. MARSCHKE: We had some representative, on this report thing that we've put together, we had some representative findings in one of the appendices. And if you look at page, if you happen to have that document, if you look at page 17, there are two representative findings on there which kind of meet this.

One was a finding on PROC-0004 which is Finding 2 from PROC-0004, which now becomes Finding 2 of PROC-0090. And we show what the SC&A initial finding was, and we show what the NIOSH initial response was. And so below that is another example from PROC-0005 that went over into PROC-0090. And again, it has the SC&A finding and the NIOSH initial response.

But as far as I know, as Kathy indicated, there has been really no working group discussion as to the adequacy of the response or does SC&A buy in with the response and so on and so forth. Does the working

group buy in with, you know, where do we stand with these things? So that's kind of, I guess, and to tell you the truth I really don't know.

MR. HINNEFELD: I would propose that certainly from our side we go back and look at findings and responses. Did we look into feasibility? Did we do that? Did we make revisions to the procedure because of this ^ where we are. And I can provide a report back to the working group well in advance of a late May meeting that would either say here's some additional things to consider on these responses or we believe our response adequately addresses it and for whatever reason we don't, you know, won't address this finding change or as we said in our response, we have now done this change or consider this modification and actually made it. So I would think that we could come back with some refreshment of our collective memory about where we are on this.

MS. MUNN: That would be very helpful. It's been many months since we addressed some of these items individually, and this will be the

first time that we will have seen them in their new, improved format.

DR. MAURO: What we're saying right now the way in which this machine which we've built, the database we built, in effect what we would have, as I understand it, there's going to be a date that says this working group meeting. And in that there's going to be a place that says this issue, this item number, PROC-0090, number two -- that's what we're talking about -- was discussed. Those are sections that, okay, what do we do during the working group meeting with regard to this? It was discussed.

And then we have to have something, an action item. It sounds like there was an action item that's coming out of this that you have directed NIOSH to prepare. Now is that material, the material that you're going to be in a position at the next meeting to discuss this?

MR. HINNEFELD: Yeah, I'll distribute it before the next meeting.

DR. MAURO: Now does that become a white paper? What does that become?

MR. HINNEFELD: If we made that entry in the database that you just suggested, it can be the next response or ^.

DR. MAURO: So it's if it's new, it's something that goes in here. If it's ^, then it becomes a white paper.

MS. BEHLING (by Telephone): Excuse me, Wanda. This is Kathy again. Just to add to this particular discussion I handled this particular procedure on actually Procedures 4, 5 and 17 a little bit different than I've done with some other procedures that were not replaced but just where we were looking at a revised document. But let me explain.

If you go into the database right now, and you go to ORAU PROC-0004, which was an initial scheduling of the telephone interviews, you'll see under the details list that we initially identified this finding in our first set on January 17th, 2005. There's a NIOSH response in there on October where there is a working group discussion that had been put in there on 7/26/2006.

And then we clearly state in there that this issue has been moved now to PROC-

0090. And we closed this item under PROC-0004 because I just thought that was a cleaner way of handling it because we're picking it up anew under PROC-0090. And so under PROC-0090, you know, same issue, same finding, but you can trace back.

And Stu should be able to go back into the database. I don't know that there'll be as much detail as he'd like, but you can go back into the details and see where, how this finding initially was identified and where it is now. But I did close it under PROC-0004.

MS. MUNN: That's what we had agreed we would do earlier, yes.

MS. BEHLING (by Telephone): Okay.

MS. MUNN: Yeah, that's good.

All right, I think we all know what we're all doing and what we anticipate. With any luck at all we can get through this without a white paper. Hopefully, we can just address these issues on the matrix itself.

NIOSH: TIB-011-01 AND -02

Review of any new response items for the matrix in addition to what Stu sent us just last week on TIB-0011, items one and two.

MR. HINNEFELD: I can give a little bit of status on this. We have, TIB-0011 was dose for respiratory tract components. I think that was the one from radon progeny ^ Joyce commented on. We provided the revised. There were, in fact, some errors in the TIB-0011 that was out there to the claimant favorable side. So an erroneously high dose was being calculated. We provided revised numbers.

Joyce wrote and said that, hey, I'm still having trouble reproducing these. Can you show the calculations? We can do that. We'll do that. The calculations are, these calculations are actually done three different ways. We did them on an Excel spreadsheet. Dave Allen put that together and that spreadsheet has a variety of calculations that aren't related, you know, unrelated.

And there's also, as you can imagine, you get a whole big spreadsheet, a workbook of Excel calculations, you've got to figure out exactly where you are so you just kind of put together sort of a Rosetta Stone to understand what's being done on the spreadsheet. In addition, our contractor did the same

calculations using IMBA Expert, which is a version of IMBA that we actually don't utilize at OCAS that our contractor has. And it has at least some portion of these radionuclides available, and so it goes through calculations and does it.

And they also did another application. I believe they used Math CAD and then just powered through the differential equations for each part of the bioassay model, the metabolic model. I would guess what he did was give the definite intervals for each year of those differential equations, and then you get total residence in the organ and then used specific effective energies from the ICRP publication, combined with the residence time.

Now you've got to be an internal dosimetry geek to worry about this stuff, which is what I am, unfortunately. And so he just powered through it that way. And the three techniques came, you know, we said there were three. Now there's some decimal changes in fractions, a percentage or two change differences amongst the three or maybe more than four percent, but just a few percent

differences among the three techniques. But with the three different calculational inputs we thought that this ^.

MS. MUNN: But they're not really significant.

MR. HINNEFELD: But it's fairly clear that when you start to do this depending on how you solve it and what you do, and what assumptions you make, you can be different. So it's important for us to make sure we could provide SC&A this is exactly what was done. And then they can either critique that or say, okay, I understand ^. So that's what we did.

We will provide those calculations, at least the Excel calculations. You know, we could provide the results from that and the results from IMBA Expert, but we couldn't really provide, I don't know that we could provide the code. I don't know if you guys use those or not, those applications. Anyway --

MR. MARSCHKE: It would be Joyce who would be looking at it.

MR. HINNEFELD: -- Joyce probably has her own way to do it.

DR. MAURO: Yeah, I think she has it, yeah.

MR. MARSCHKE: That's why I think she wants to basically compare the way you did it to what she's doing because whatever she's doing, you know, implied from the e-mail it doesn't --

MR. HINNEFELD: She'll get the same answer and so it may be, I'm thinking it's probably some sort of assumptions that go into doing the calculation versus the actual calculation answer.

DR. MAURO: What I hear is two action items. NIOSH to provide SC&A with a spreadsheet as you see appropriate that we will need. And that SC&A, once we receive that material, we will review it and check the numbers. Because right now we were unable to confirm the numbers that have been provided.

MS. MUNN: I'm glad you articulated that for me because my next question was going to be, all right, what do we do next.

MR. HINNEFELD: Other things that I can report on real quickly, we have a series of findings on our, you know, OCAS Procedure 5, which is our conduct of assessment procedure.

Since we do have some responses, and, in fact, have made a series of revisions to PROC-0005, draft revisions, in response to that. So I could provide that to the work group forthwith.

MS. MUNN: Good.

MR. HINNEFELD: And we do have a draft internal of some responses to Findings OTIB-0018-hyphen-0005 and -0006 that we'll provide forthwith in our ^.

MS. MUNN: So we'll expect two additional items from you.

DR. MAURO: Wanda, as this new material comes in and it's loaded up into the database by NIOSH, I guess there's some question of whether or not we look at it and review it or do we wait to get direction for us to do it? Right now we did get direction when we received the spreadsheet related to this ^ respiratory tract, we have been authorized to look at.

MS. MUNN: Yes.

DR. MAURO: We will. But now there are a number of other places where material apparently is going to be loaded up into the

database which may or may not. Should we wait until you have a chance to look it and we regroup, and then you can decide whether or not you'd like for us to look at it? Or do we automatically look at new material as it comes in?

MS. MUNN: I would like to say go off and look at all new material as it comes in, but I don't think that's practicable, at least not immediately. I don't think that's practical. It appears to me -- and please other work group members stop me if I'm incorrect -- it appears to me that we are going to need to use the new matrix for a couple of work group meetings to get familiar with my proposed process of simply printing out the open and in abeyance summaries as our marching orders and identifying our priorities from those at each meeting.

Does anyone have any other feelings about that? It just seems precipitous to me for us to say, no, as things show up, go look at them. I think the work group needs --

MR. HINNEFELD: There will be an opportunity to decide as I provide, if I provide

something, I'll provide it to the work group, and I'll provide it to SC&A, I mean, just for ease. And at that point you can have a discussion about which of these, you know, you might be able to read from the initial read of our response whether you think it warrants ^ evaluation, additional follow on or whether, for instance, if we say we agreed we would provide PROC-0092 to address this, and we send you some words, you know, the draft words in draft PROC-0092 are this. And you say, okay, that's what we wanted, well, you know, that's ^. So it can be decided at the time the information is provided rather than decided in advance.

MS. MUNN: It seems to me that if we don't work out the mechanics of exactly how this is going to go, and it will take us, I think, a couple of meetings to work out the kinks, that we may not only miss some of the open items, but we also may get at cross purposes and have people working on something that's less pressing than perhaps other things that the work group would wish to address. We'll work on the assumption that that's ^ for the next

couple of meetings anyway.

DR. ZIEMER: I agree. I think that's appropriate.

MS. MUNN: SC&A, are you ready, John? There are a couple of things. Do we want to address the question of the overview and summary results for the first set and what our feelings are with respect to bringing this as it is to the Board or making any suggestions? Or do we want to go to the review of PER-9? Which would you prefer?

SC&A: REVIEW OF PER-9

DR. MAURO: I would say since this is on the agenda, I know Hans, I believe Hans is on the line, and he's actively involved in PER-9, maybe we can get a briefing on where that stands, and that shouldn't take too long.

MS. MUNN: Very good. Are you with us Hans?

DR. BEHLING (by Telephone): Yes, I am.

MS. MUNN: Excellent. It sounds like you're on stage.

DR. BEHLING (by Telephone): Do I have the approximately the half hour that's on the agenda for discussing this issue?

MS. MUNN: Correct.

DR. BEHLING (by Telephone): Well, let me just refresh everyone's mind as to what this is about. We're talking about under Task Three we were asked to look at some PERs. And the one that is probably foremost in terms of importance is PER-9, Program Evaluation Number 9 Report. And that particular PER centers around the selection of target organs that involve lymphatic and hemopoietic cancers. And let me just give an overview as to why that is important.

To go back to the understanding of how certain types of lymphoid tissues are affected, we have to go back to ICRP-66 report which talks about the pass-through blow model and how when you inhale certain radio particulates into the lung, that they are also transferred. One of the major clearance mechanisms for the clearing of the lung of radio particulates, is by way of alveolar macrophages which takes, phagocytizes these micro particulates and transfer them to the lymph nodes.

And at that point through ^cytosis and use of various enzymes, these materials are

basically regurgitated by macrophages and are now in the proximity of lymphoid tissue. And what has happened therefore, is that we have a potential for concentrating radioactivity in small volumes of lymphoid tissue that will ultimately give rise to doses that can be much higher than you get in the lung tissue.

In fact, if you're talking about the radionuclides that are of particular concerns we're talking about, alpha emitting particles or isotopes that obviously include plutonium, uranium, americium and thorium, and, of course, when you have an alpha emitter in close proximity to cells, you get a very, very high dose.

And just for a sense of getting an understanding, if you look at the dose on a relative scale for an isotope that is an alpha emitter, and you compare the dose to the lung versus to lymph nodes of the thoracic area, you will possibly get doses that are a couple of orders of magnitude higher. And, of course, that's even further emphasized when we talk about in days past when lymph nodes or lymphomas were reconstructed using the highest

non-metabolic organ, which in most instances was then the colon.

So you can understand the impact of this particular revision that defines PER-9. That is, using target organ that in days past, prior to February 10th, 2006, were dose reconstructed using non-metabolic organs, when in fact they should have used lymph nodes.

And as I said, you can be talking about differences now in days past versus under the new regimes of dose reconstruction we can talk about differences up to three orders of magnitude in doses. So we're not talking about percentage values by orders of magnitude that might impact previous dose reconstructions done under the original method versus the revised method.

Anyway, just to bring you up to date, as a result of this issue for PER-9, NIOSH has revised two major documents. One of these is OCAS TIB-012 or 12, and the other one is ORAU OTIB-0005. And these are now going to reflect the revision in organs that will be selected for dose reconstruction.

And there are two types as I've

already mentioned. The internal organ target organ will frequently now involve for many lymphomas the thoracic lymph nodes or the extrathoracic lymph nodes as opposed to in days past, the highest non-metabolic organ. In addition to that which is really the major driver to that, external organs have also been revised. So these two documents, OCAS TIB-0012 and ORAU OTIB-0005, have revised in some instances external as well as internal target organs for various lymphomas.

And just to bring you up to date as part of the PER, NIOSH went back and looked at the universe of lymphomas that have been reconstructed under the old method and which resulted in a POC of less than 50 percent. Those are the ones that obviously were of concern. And they identified at total of 528 cases. There were a total of 28 cases that for some reason or other were not, they were affected by other issues, and so we were left with 500 cases.

And so NIOSH reevaluated these 500 cases in the current or revised TIB and OTIB as I've just mentioned, and on the basis of

that reevaluation a total of 152 cases that were formerly defined by POC values of less than 50 percent, have now exceeded the 50 percent value and have been compensated. And, of course, that leaves a total of 348 of the 500 cases that were reevaluated but under the new guidance documents still had POC levels of less than 50 percent; and therefore, they still remain as denied claims.

Anyway, I have begun to review what we were asked to do in terms of evaluating PER-9, and if you recall, we had submitted the protocol for doing so. And in the protocol we had just briefly identified five subtasks in behalf of each of these reviews. And at this point in time I have completed subtasks one through four, and I've yet to start in subtask five.

And subtask five I'll just postpone it, but I'll mention briefly, is really the nuts and bolts of this issue, at least it would appear. Because under subtask five we were supposed to conduct audits of dose reconstructions that were affected by the PER under review. So that at this point we have

yet to review a particular dose reconstruction that has been reevaluated under PER-9. And the reason we haven't done so is because the work group has not at this point made its selection of the particular DRs that we are to review.

And I think in part I want to talk about and talk to you, Wanda, and the other members of the work group in trying to figure out how to go about making a selection of the particular DRs that we are to review. And it's not just a random selection of the 348 cases that are likely to be the universe of cases, but I think we may want to have a more focused selection, and I'll discuss that later.

But let me briefly talk about where we are today with regard to the first four tasks. In reviewing the basis -- and under subtask three let me briefly talk what subtask three was looking for us to do.

And under subtask three -- and I'll quote from our proposal -- we were to assess NIOSH's specific method for corrective actions. In an instance where the PER

involves a technical issue, SC&A will review the scientific basis and/or sources of information to ensure the credibility of the corrective action and the consistency with current and consensus science.

Anyway, what it means is that I went over, and I looked at the revisions to OCAS TIB-0012 and OTIB-0005, and with that NIOSH consulted with two outside experts, one of whom is a medical doctor who is certified in internal medicine as well as in hematology. And the other outside expert that NIOSH used is Dr. Keith Eckerman who is well known in the circles of Health Physics. ^ of internal dosimetry and familiarity with ICRP-66 and so on.

And then looking at these revisions, as I said, many, many of the lymphomas have been revised in terms of their ICD-9 codes and with the selected internal and external target organs are now reconstruction doses. Also, in looking at that data, and there have been many, many changes, I also came to some concerns about whether or not there are some issues that have yet to be resolved.

And let me just briefly talk about what my concerns are. When we look at the ICD-9 codes, we realize there are somewhat contemporary segregation of lymphomas that reflect on the current day methods for oncologists and pathologists who are in a position to look at a biopsy and determine what is the cell line from which this particular neoplasm was derived, and that is not a hard science.

It has certainly changed over the years and has improved, but looking at Dr. Carlton's report that he submitted to NIOSH -- he was asked to sort of look at this and come to some conclusions as to how to go about making these changes and also in behalf of Dr. Eckerman's report. It certainly raised a number of issues in my mind.

And those issues center around how accurate can we at this point in time look at a particular lymphoma and somehow or other determine on the basis of existing pathology reports and pigeonhole that into an ICD-9 code that now determines which external or internal target organ should be used for dose

reconstruction?

And it’s clear that there are very, very definite questions about the ability to do so. And I know from my own pathology books, and when I went in graduate school I took a course in pathology, and the textbook we used, and I reference this in my write up is Cecil, which had a publication date of 1979. And I reviewed some of this documentation that involves lymphoreticular neoplasms, and they are not an easy bunch to diagnose, specifically, the non-Hodgkin’s lymphoma because it really represents a fairly heterogeneous group of neoplasms.

Heterogeneous meaning that it represents a host of lymphoid tissues from bone marrow-derived lymphocytes, thymus-derived lymphocytes, macrophages and mononuclear cells. And, of course, like all cancers we’re not dealing with mature cells, but we’re dealing with a whole spectrum of cells that range from the very, very primitive stem cells from which all of these cells are derived, but intermediate cells in various stages of cell differentiation.

And where I, in terms of going over my pathology book, and I looked at it again the various diagnostic tools that are used to establish what is the cell of origin because it's very critical to identify the cell of origin in the treatment of these cells. Some of these lymphomas are extremely radiosensitive; some are more sensitive to chemotherapy. So it's imperative that the oncologist and pathologist get to understand what is the cell of origin in giving the patient his best chance of treating that particular cancer.

And what you repeatedly find as of 1979 in my text is that there was a tremendous amount of uncertainty with regard to how to classify the particular neoplasms, specifically those that are of non-Hodgkin's types. The Hodgkin's lymphoma is fairly easily because it's a single cell. It's called the Reed Sternberg cell, and it is clearly a cell that is readily recognizable even under light microscope. The other cells of non-Hodgkin's type lymphoma are very complex and sometimes the oncologist is forced

to say I really don't know where this came from.

And we don't ^ neoplastic cell really reflect its origin or identifies its origin. And what it really comes down to is this. We may have some very good idea today in contemporary science because our clinical methods for distinguishing these various neoplasms have certainly improved, mostly in the field of immunology. Immunology took a great leap forward in the 1980s and 1990s.

And what really concerns me today is that when we have a claimant whose lymphoma was diagnosed 20, 30 years ago, well before these very, very definitive and more sophisticated methods came about in defining the cell of origin, what do we do in terms of looking at a reference for that claimant, his medical records, and in today's world decide which ICD-9 code does this particular cancer really fit into?

Because it's extremely critical when you have certain types of cancer that will determine whether or not the internal target organ is the lymph node thoracic or is it the

extrathoracic lymph node or it may be the spleen or it may be the bone marrow. And depending on which ICD-9 code is assigned to these particular lymphomas, you're going to see potential dose reconstructions suddenly vary by orders of magnitude and determine whether or not a claimant will have a favorable dose reconstruction that will be compensated or denied.

And I have to be honest with you. In looking at the information, I believe it's still premature for us to go to the next subtask five and say we're ready to do an audit and close the book on this. I believe that it's important for us to review what has been done to PER-9, which target organs have been selected and where are there still tremendous uncertainties.

And I believe even NIOSH in looking at the revised TIB and OTIB has come to the conclusion that, yes, with these types of cancers including leukemias which are generally thought to be of bone marrow origin. There's tremendous uncertainties in the literature in the text as I've uncovered among

the specialists in oncology, there's still uncertainty whether or not you classify a leukemia as leukemia or if there is uncertainty as to whether or not it's a lymphoma.

And as I said, it would make a tremendous difference in terms of how you reconstruct doses. I believe we may want to have another sit down session and perhaps engage people who are clinically skilled and experienced in giving us some kind of an understanding as where is the uncertainty in defining certain types of cancers and are we necessarily claimant favorable in saying, well, it's most likely the tissue that was derived from the bone marrow. But would it what they most likely mean is that if it is the 90^{th} percentile, 95^{th} percentile, and at what point do we violate the uncertainty issue in being claimant favorable and when we don't really have a definitive answer.

And as I said, I'm going to be writing something up here, and I will want to forward this to the working group and let the working group make its decision as to whether or not

it warrants some additional discussion as to how sure are we when we say, no, it's not the lymph nodes of the thoracic region or the extrathoracic region, but it is, in fact, the spleen or the marrow or some other higher non-metabolic organ which will certainly make a big, big difference to the claimant in terms of whether or not he will have a POC that exceeds the 50th percentile.

So I just wanted to make that as an issue. I think I will write this up, and hopefully have it in the working group's hands in a matter of a week or so when I finalize my statements. And then I think the working group may have to have a teleconference call and discuss whether or not an additional discussion is necessary that may bring together perhaps an expert in the field of oncology and perhaps in the fields where the specialist dealing with the various types of lymphoma, Burkitt's lymphoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, and hemopoietic cancers generally speaking.

So I think having said that I also want to go back and perhaps we can add the

final touch to the issue, and I mentioned that we have not yet done subtask five and that is the selection of the types of dose reconstructions that the working group will have to select for us to do an audit on.

And the reason I say this is that I mentioned to you up front the universe of lymphomas that were initially evaluated were 500. One fifty-two were compensated now, so that leaves 348, and that is basically now the universe from which the working group may have to select a group of DRs that we will now audit.

But I think not all DRs under that 348 group is necessarily of equal value, and let me explain why. What NIOSH did, and graciously so, they said we are going to look at all lymphomas that were less than 50 percent regardless of whether or not the POC, the original POC, was zero or approaching zero or up to 49.9 percent.

So at this point the 348 cases that represent the universe for the working group to select from represented a very, very broad spectrum of a value the DRs. And what I would

like to do is sort of focus on perhaps those DRs where an audit could potentially uncover an issue that may require some additional assessment, and let me briefly point out what they may be.

I think it is worthwhile to have a spreadsheet of the 348 cases -- and I think NIOSH could readily do this without a lot of work -- that would identify these DRs, one through 348, and then identify certain characteristics of that reevaluation. Determine whether or not, for instance, the original DR for those 348 was a maximized dose or a best estimate dose, and that’s going to be a big difference.

If we are going to review a previous maximized dose, that would mean we would not only evaluate this particular case in the context of PER-9, but clearly with the likely higher doses that might be assigned as a result of PER-9, they may take away again other doses that under the maximized dose reconstruction will no longer be handed to this particular claimant. So our dose reevaluation for that case would be a

comprehensive one.

On a contrary, if the original dose reconstruction for a case was as a starting point a best estimate, then we're only going to be looking at the issues that are addressed under PER-9. So it would be very important for us to identify up front the 348 cases where the original DR was a maximized dose or a best estimate.

The other thing I'd like to see is what is the new or revised POC that obviously all of the 348 are still below 50 percent. Wouldn't it be nice to know whether or not we have in some cases a revised POC that is the 40s, 40 percent or higher? It would be nice to know that.

It would be nice to know why this particular dose reconstruction was devalued. Was it due to the fact that under the revised OTIB-0012 and -0005, was it due to a revision to the internal target organ or the external target organ or the internal and external? I would be very definitely interested in focusing on the, principally, the revision to the internal target organ and perhaps the

internal and external. If it's strictly external chances are it wouldn't really matter a whole much anyway.

The other thing that I would like to see is what is the type of lymphoma? What were the classification? Under what classification was this, this reevaluation was made? So it would be nice to understand for the 348 DRs what was the assigned ICD-9 codes.

And let me see here. I had a couple of other issues that I wanted to look at. I've lost it, but I will provide the working group with a spreadsheet-type of format that will identify the things that we may want to look at in saying this is very important and for the work group to consider so that we're only going to be looking at, I believe, three or four or five DRs as part of this PER-9 evaluation.

So it would be very wise to make a selection of those cases where we get the most bang for the buck, and looking at those cases where we really have a vested interest in determining whether or not the PER-9 did what we expected it to do. So I think I will leave

or open up the door for questions here if anybody has any questions that involve any of the stuff that I just talked about.

MS. MUNN: Hans, your suggestion with respect to our focusing our specific attention is certainly well taken. I'll have to admit you covered so much material in such depth, and I don't know about the other folks around the table, I'm overwhelmed and probably will not be able to fully grasp what you've had to say until I see your written report. It will be very helpful for me to be able to think about the issues with the information clearly in front of me.

I believe Larry has a comment.

MR. ELLIOTT: Yeah, this is Larry Elliott. I wanted to interject a comment at this point. Excellent summation, Hans, of the science behind this change. NIOSH would agree with I think all of the comments that you have made about ICD-9 codes changing over time, the difficulty in diagnostic techniques as they developed over time, the application in dose reconstruction in our decision-making process.

One thing I think, however, that I

didn't hear in your report, and I think this goes really to the end game here, what NIOSH does with these particular types of dose reconstructions for lymphoma is we run a series against different target organs, and we take the most claimant, the highest POC that makes the --

Am I correct in this, my thinking here, Stu?

MR. HINNEFELD: I don't believe so. I believe TIB-0005 specifies a specific target organ for internal and external, but now --

DR. ZIEMER: I thought on the change that you were going to do what you described. Maybe that hasn't been initiated yet.

MR. ELLIOTT: Oh, it's been initiated, and I believe Jim Neton would be the expert to talk and speak about this. But I believe based upon the information within a particular claim, the ICD-9 code that is reported and the site of the cancer or the cell --

DR. ZIEMER: Yeah, the site of the cancer becomes the driver.

MR. ELLIOTT: It becomes the driver. And we select different --

DR. ZIEMER: I mean, it doesn't matter what the dose is to the other sites if there's no cancer there, does it?

MR. HINNEFELD: Well, the issue with lymphoma is that the lymphoma tissue circulates, and so if you find a lymphoma in your armpit, for instance, it develops in your armpit. It does not mean that your armpit was the origin for the cancer. And so there are a lot of specific descriptions of cancer, whether you go by the written description or ICD-9 code, where I think it's TIB-0005 addressed the dose reconstructor to use, for this ICD-9 code use this internal target organ if any of those say thoracic lymph nodes.

DR. BEHLING (by Telephone): Let me add to that, the point well taken, Stu. The issue of lymphomas is really driven by the stage in which the cancer's detected. If it's a very superficial primary lesion that is readily recognized such as in the groin, the inguinal glands or under the armpit, oftentimes that particular, initial awareness of the lymphoma is also one that allows you to make a very early diagnosis under Stage I. Stage I

meaning that there is a single lesion, and at that point you don’t worry about any other secondary cancers.

On the contrary, when you have a lymphoma that has its origin deep in, let’s say, in the chest cavity, you may not be aware of it, and the only time you do become aware of it is when the lymphoma spreads to secondary lymph nodes that are now visible. Because oftentimes these lymphomas may exist for years, and they’re painless. They do not present a problem. And it’s only when something triggers their diagnosis that you may now be in Stage II, III or IV that you become aware of it.

Now the problem then is when a biopsy is taken, it’s usually not one that necessarily involves the primary lesion if it turns out that the primary lesion may have occurred in the chest because of the lack of ^ and the pain and all the other issues. So what’s happened is the physician will take a biopsy of the most readily available area of, or the lymph node that is most accessible; and therefore, that particular lymph node may not

be the primary lesion at all.

And so I think what you have to look at is what is the stage in which this particular lymphoma was diagnosed. And if you're fortunate enough, your Stage I lymphoma is confined to a single lymph node. And, of course, then you're correct, Dr. Ziemer, in saying that's the area where it most likely would be the exposure took place, but that would only be confined to Stage I-type lymphomas.

DR. MAURO: Hans, would I be correct then in the selection process of which ones we'd look at, the place where the underestimate might lie are for those cases where the person was diagnosed with, let's say, a Stage III, Stage IV. And it's under those circumstances where you could misdiagnose the organ of origin and possibly underestimate the dose by quite a bit.

DR. BEHLING (by Telephone): Yes. In fact, and, of course, I would also focus on claims where the diagnosis occurred 20 years ago. As a former, I used to be very much involved in immunology before I went back to Health

Physics. And I'm aware of the many immunological techniques, cell surface markers that differentiate the T-cells from D-cells and the natural cure cells and all these things.

Those were these monoclonal antibodies that are used for ^ antibody techniques that we use so much today as diagnostic tools for establishing cell lines for cancerous cells. Those are things that didn't exist before 1975 or '80. Those things came in more recent years.

And I would be very interested in looking at some of the claimants' cases where the lymphoma was diagnosed in the '50s and '60s and '70s or in the later years and understand where difficulties that may exist in trying to somehow or other, as I mentioned, pigeonhole a claim that's involved in lymphoma that was diagnosed, let's say, in the late '60s or early '70s, long before ICD-9 codes came in.

In fact, one of the things that you will see in my write up, I went back to my own pathology textbook, and it gives you the

nomenclature changes that occurred in medical text that even pre-date the ICD-9 codes. And so you have a real problem here in trying to figure out what to do in dose, particularly in lymphomas, that were diagnosed decades ago in trying to somehow or other pigeonhole them in today's ICD-9 codes on the basis of which we now have to do dose reconstruction using internal and external target organs.

MR. HINNEFELD: If I could offer perhaps a pathway here based on something we've talked about. First of all, understand you're going to deliver a report that at least includes the subtask three work that you're describing.

DR. BEHLING (by Telephone): Yes.

MR. HINNEFELD: And it may be appropriate at that time for NIOSH to prepare bases for selections of target organs and focus on the ones that did not select thoracic lymph because the thoracic lymph nodes for someone who's exposed internally is the sweet spot essentially in these diagnoses. That gives you the largest, it's the largest exposed tissue from an inhalation of an alpha emitter, if an alpha emitter has any kind of retention

time in the lung at all, or a long retention time in the lung. So not since NIOSH made the decision, and I am really not the guy to carry this conversation, but since NIOSH made the decision that not every ICD-9 code will we consider the thoracic lymph the target organ, there must be a reason why certain ICD-9 codes were not included.

So it would be at that point that NIOSH could provide a basis for the decision making that selected other internal target organs for certain ICD-9 codes and based upon Hans' write-up which focuses on history which as I understand it is exactly right on how these things, you know, they're very difficult to diagnose today let alone long ago.

And so the justification for this selection should have some sort of temporal aspect to it. As you go back in history why you feel okay that this, and what do you know about the process and why you feel that this is okay to select this other target organ besides thoracic lymph. So that then can address that fundamental issue of why that rather than to try to select based on that

kind of issue, you select cases based on that and try to solve it that way, let's try to solve that question based on --

DR. BEHLING (by Telephone): The issue is really one of time here and the date of diagnosis will be a pretty good variable. And while you were talking, I just thought about the one variable that I couldn't recall off the top of my head. But it is also one that I'd be glad to include in the matrix, and that is one lymphoma case.

This involves a person who had a known exposure to an alpha emitting radionuclide. I think that's very important for us to know. Was there a reason to suspect that he was exposed to an airborne environment involving plutonium, americium, uranium and thorium?

I think it's very important because as you mentioned, this is the critical group of people because when you have an alpha emitter that's in the lung, and it's transported to the regional lymph nodes, this is where the big doses come into play. If the person was exposed to an excretion product involving beta and gammas, okay. It'll make a difference,

but the dramatic difference really comes into play when we deal with an airborne exposure that involves an alpha emitter.

MR. HINNEFELD: So we can, okay, Hans, you suggested that you would send essentially a format for this spreadsheet to show the various characteristics. If you would do that, I'm pretty confident we can sort these, put these 348-some-odd cases in the spreadsheet you request. I'm pretty sure we can do that.

DR. BEHLING (by Telephone): I don't think it will take you that long. I would think we obviously know the date of the diagnosis. You know the type of lymphoma, the ICD-9 code that was used. You know what the new POC was. You know whether or not the original dose reconstruction was either a best estimate or a maximized dose. So I don't think it will take you that long to go through that, but it will certainly improve the likelihood of us doing a dose audit evaluation that says let's focus on the ones where it really counts.

MR. HINNEFELD: Right, we can take care of that. I'm certain that these will be easy and

others will take a little work, but it won't, it shouldn't take that much time.

DR. BEHLING (by Telephone): Let me also ask you something. I don't want to speak cynically of Dr. Carlton, but he's certified in internal medicine, and he's a hematologist. And I did look, I Googled him and so forth, but I don't think he really has the clinical expertise that you would like to have, and that would involve a person who, let's say he works for M.D. Anderson, who's an oncologist who's very, very much involved on a day-to-day basis with the clinical diagnostic methods used to establish these types of cancers, hopefully, lymphomas.

Is there somebody else that NIOSH has looked at for perhaps serving in that capacity? Even if you're looking at somebody who may not be an oncologist per se, but Dr. Neal Waldon was one of my former mentors when I was at the University of Pittsburgh. He's extremely well versed obviously in the issue of hematology but also how it relates to cancer and how it relates to radiation issues because he was one of the key members early on

involving the A-bomb survivor studies.

Is there any other individual that you might want to think about in terms of giving him an option to assess this whole issue of the PER-9?

MR. ELLIOTT: That's up to the working group. That's not up to NIOSH.

MS. MUNN: One of my questions was going to be who would be your dream team if you actually had access to almost anyone that you knew of who might be expert in these particular matters, but my second question that comes to my mind is do we have the financial resources and the authority to go get that person? I have no feel at all whether there is authority vested in this group to suggest that such expertise be made available to us.

DR. BEHLING (by Telephone): Well, I am sure that you can probably go through the National Academy of Sciences with your people and come up with someone who is not only versed on the radiological issues and cancers but also has the clinical expertise. As I said, I don't want to speak negatively about Dr. Carlton,

but I don't think he has the clinical experience.

Although, as I said, when I read his report, he was not exactly shy about saying that there are a tremendous amount of uncertainties that you introduce in trying to make a diagnostic decision as to where this cancer came from. It's clear. It's a very short report he wrote, but you can certainly gather that he is not necessarily one that says the ICD-9 code is an easy code to use in labeling a lymphoma even by today's standards.

MS. MUNN: I suspect that several of us know individuals who, if not adequate in specific expertise, are certainly well informed with respect to individuals who would fit that category and could probably provide the names of two or three individuals who would certainly be acceptable to almost anyone. But my question still remains as to whether or not we are authorized to do that, having no feel at all --

DR. BRANCHE: I can tell you.

MS. MUNN: Yes, good.

DR. BRANCHE: I think that the resources

that we have set aside for the Board serve the needs of the Board given their current level of activity. I would hate to give you the impression that there are other resources available to contract with additional expertise. We can check into that further, but I would suspect that this is a very resource-poor period of time to bring in additional resources for this.

DR. BEHLING (by Telephone): Under that circumstance --

DR. BRANCHE: Dr. Ziemer wants to say something.

DR. ZIEMER: Well, I'm just wondering if SC&A under their own contract couldn't pull in someone like Neal Long as a consultant to them if you had specific issues that you wanted Neal to help with, Neal Long or Fred Mettler would be another one.

DR. MAURO: I'm seeing this as a next step issue. There are going to be a collection of cases that were denied, that were old diagnosis some time and where the dose was not derived from a thoracic component. There will be a collection of them which we'll zero in.

And then we have a group of people sitting around a table talk about those cases and the diagnoses, and where in those cases, let's say, they use the colon as your surrogate for the dose reconstruction.

And we're going to ask ourselves and Fred Mettler or Neal Long is it reasonable under these circumstances for this case, see, we're looking for are there any cases where it would have been not unreasonable to say, well, no, no, no, we shouldn't have got, if you wanted to really give the benefit of the doubt to this guy, we should have assumed not the colon, not the spleen. We should have assumed thoracic lymphoma. I think that kind of judgment could emerge from a meeting.

DR. ZIEMER: I don't think it's SC&A's task to identify the cases. You might want to, if there's one that sort of proves the principle, that makes a big difference, it seems to me that the burden is always on NIOSH to go back and say we're going to review all the cases or cases that have these characteristics.

Even if you bring on an example that shows that the dose is ten times different,

but it didn't change the outcome, as long as you prove the principle that this has an impact, it seems to me it's NIOSH's job. I would not like to see SC&A searching through to find all the cases that were missed or necessarily say we're going to search till we find a case.

DR. MAURO: I agree with you.

DR. ZIEMER: It's true that you want to find one that's a good representative and say does it make much difference. What's the best case to select? But to put a big kind of effort into this and bring in a blue ribbon committee of consultants to do it, I don't think you need to do that. We'll use our best judgment.

If we need to consult with a couple people and pay them a few hours of time, I don't think it's a big deal, but I'm just concerned that there's a tendency for the Board and its contractors to out-step our boundaries and say, well, we're going to do this because it needs to be done. Now, if it needs to be done in a more inclusive way, then it becomes NIOSH's task.

DR. BRANCHE: Well said. Well said.

DR. MAURO: Absolutely. What we were hoping to accomplish is to sensitize this working group and NIOSH with this concern. From here, really, the baton is now, this is our concern. We sort of passed on our concern, and I think you fully understand where our concern is coming from. And now it's just really a matter of the degree to what does NIOSH think is the reasonable thing to do to deal with this concern. Quite frankly, I think we're out of the picture now.

DR. BEHLING (by Telephone): Let me also make a comment in regard to our budget constraints and so forth. But I'm looking obviously at this work group that is this moment chairing this whole issue, and allow we have wonderful people with lots of qualifications, but I would as a minimum like to add perhaps to this work group for this particular issue the two medical doctors that we have on the Board, Lockey and Melius, and perhaps engage them in a minimum way to review this issue.

DR. ZIEMER: Again, and I'm looking at the wording of the subtask right now. The subtask

shows up in the proposal to David Staudt dated June 22nd. And it says, “Evaluate the P-E-R-stated approach for identifying the universe of potentially affected DRs and assess the criteria by which a subset of affected DRs were selected.” And then, let’s see, well, that’s the focus.

DR. MAURO: To me it’s pretty straightforward. We owe the working group a report. Hans is basically close to finishing the report. We’re going to deliver it, and then after that the working group makes its decision on the next steps to take. I think what Hans did is basically give you the verbal of what that report’s going to look like.

DR. ZIEMER: But this doesn’t require that we even do a DR review.

DR. MAURO: I think case 0-5 --

DR. ZIEMER: Oh, 0-5 --

DR. MAURO: -- and we’re recommending not to do it. In effect what we’re saying is you may have an expectation because our proposal said we would do that. What we’re saying is no, it probably is premature for us to do it before you have a chance to look at this issue. And

if you decide after looking at the material that Hans delivers, yes, it would be a good idea to pick a couple of cases, picking that case is going to be done by the working group with appropriate consultation. And only at that point do we come back in again.

DR. BRANCHE: Right.

MS. MUNN: I'm reluctant to leave this issue, but we don't really and truly have any choice. We're constrained by the fact that we have another work group that has to be on the line at three o'clock.

DR. ZIEMER: And we haven't really got the official report from Hans yet either.

MS. MUNN: And we can't leave this hanging until our next meeting. That just simply won't do.

CALENDAR ITEMS

So, Hans, do you have a feel as to when we may have your report? It's going to be my recommendation that once we know what that time is that we schedule a teleconference of this group for an hour or two hour conference, something of that sort, to pin down specifically who has what action and how

we will proceed from there if that's amenable with everybody. So the ball is in your court right now with respect to what's the timing need to be.

DR. BEHLING (by Telephone): Okay, I think I can probably have a draft report available to the working group probably within ten days.

MS. MUNN: That's good. So that would be by the end of, that's putting us close to the end of March. Could we take you at your word strongly enough to talk about the possibility of a teleconference on the 27th or 28th of this month?

DR. BEHLING (by Telephone): I think so. The 28th is the, I hear Kathy, because she's supporting me in this effort, she say's the 28th. I always listen to the boss.

DR. BRANCHE: I'm not available that day, but I am working on a group of people to be a substitute DFO. But I have not confirmed that, so that day right now is not, neither of those two days are good for me.

MS. MUNN: Okay.

DR. BEHLING (by Telephone): There are work group meetings on the 25th and 26th which I'm

part of.

MS. MUNN: That's correct. Yes, I'm aware of those, but apparently the 27th and 28th are out as well which puts us into April.

DR. BRANCHE: Well, the 31st of March, that Monday, is a possibility. There's a Mound working group on the first, and if you want to do it by conference call, I would say the second or the third. I wouldn't do the fourth simply because it's the last working day before we meet in Tampa, if the 31st or second are amenable to you, Wanda.

MS. MUNN: I'm already going to be in Florida that weekend, but we can't move it earlier because he won't have it ready.

MS. HOWELL: Are all of the working group meetings scheduled for full days? I mean, we couldn't --

DR. BRANCHE: Yes, absolutely. The Fernald and the Subcommittee and Mound are all full day meetings.

MS. MUNN: They'll be full days. We can't get around them, no question about it. And so we can't move them earlier than that. Tuesday, the first?

DR. BRANCHE: That's Mound.

MS. MUNN: Wednesday, the second?

DR. BRANCHE: I could do that.

MS. MUNN: Is Wednesday, the second, amenable to everybody who's on this call?

MS. HOMOKI-TITUS (by Telephone): Yes, Dr. Branche, I just wanted to let you know the Office of General Counsel won't be available until 11 o'clock that day.

MS. MUNN: Until 11 o'clock eastern?

MS. HOMOKI-TITUS (by Telephone): Yes.

MS. MUNN: That would just be delightful for me if we scheduled it for Wednesday afternoon, April 2nd.

DR. BRANCHE: Would you want to do it at 11 or at one, eastern time?

MS. MUNN: Let's say one eastern time.

DR. BRANCHE: And that's going to be a conference call?

MS. MUNN: Yeah, conference call specifically on review of Hans' document which we will then have in hand.

DR. BRANCHE: And then you wanted to schedule another meeting face-to-face, did you not?

MS. MUNN: Yes, we do want to schedule another meeting face-to-face. I would suggest the third week in May.

DR. BRANCHE: The week of May 19th?

MS. MUNN: Yes, correct.

Mark and Mike, are you still on the line out there?

MR. GRIFFON (by Telephone): Yes.

MR. GIBSON (by Telephone): Yeah, I'm still here.

MS. MUNN: Are these dates sounding okay to you?

MR. GIBSON (by Telephone): What's the one in May again?

MS. MUNN: We're talking about the week of the 19th. I would suggest probably Tuesday, the 20th, face-to-face, Procedures, here.

DR. ZIEMER: I can't be here, but I can probably call in.

MS. MUNN: How about later in that week?

DR. ZIEMER: I'm out all week.

MS. MUNN: The entire week is the same thing.

MR. GRIFFON (by Telephone): May the 20th is okay for me, Wanda.

MS. MUNN: Okay, let's do May 20, Procedures, face-to-face, Cincinnati.

DR. BRANCHE: Do you want to start at nine or 9:30?

MS. MUNN: Prefer 9:30, but it will be all day. We will not shorten this at all.

DR. BRANCHE: Do you prefer to go until about four?

MS. MUNN: Probably five.

DR. BRANCHE: Five. Eastern time.

MS. MUNN: Correct.

Now, there's one other item we still have not covered that I definitely wanted us to be able to talk about before the Pinellas meeting, and that's the one that's the overview and summary results for the first seven of 33 procedure reviews and what we are going to bring to the full Board at Pinellas. We need to have something on there in their hands before time so that this will not come as completely new information to them.

If we're going to do that, then we're going to have to talk about it on the telephone beforehand. Since we already have that document in hand, and I shouldn't think

this will take us more than an hour or two hours at the most to discuss, I'd like for us to do this fairly early on here. Is there any possibility that we can do this for an hour next week? How about the 19th, Wednesday the 19th, an hour early in the afternoon, one to three eastern time?

DR. ZIEMER: We're going to discuss --

DR. BRANCHE: The presentation to the Board.

DR. ZIEMER: Kathy's presentation?

MS. MUNN: No, we're going to discuss this overview and summary which we haven't had a chance to talk about.

DR. BRANCHE: You're going to do that by conference call?

MS. MUNN: Yes, conference call.

DR. BRANCHE: Can you push that back to, can make it two to four?

MS. MUNN: No problem for me. Is two to four a problem for anyone --

DR. BRANCHE: There are a lot of people speaking. Wanda's trying to speak here.

MS. MUNN: Is two to four on the 19th adequate for everyone, two to four eastern time?

MR. GRIFFON (by Telephone): That will work for me, Wanda.

MS. MUNN: Okay. A single item, we're just going to be talking about this overview and summary results that John's provided to us. Whether that's overkill. Whether it's underkill. What do we want to take to the Board? All right?

DR. BRANCHE: One last question. Does anyone have any objection to our, we're thinking about, because this information hinges on what other work groups will see and have access to, do you have any objection to our attorneys having access to see it? No write access, just to be able to see on the database that Kathy's put together. They need to be given access. They don't have it now.

MR. HINNEFELD: No, we can develop it and get it periodically and put it where they can see it.

DR. BRANCHE: Okay, let's do that. So I'll work with NIOSH to do that.

MR. HINNEFELD: We'll just have to arrange with ORAU to get it periodically so they can see it as of such-and-such a date.

DR. BRANCHE: I'm trying to get us off the line. I didn't mean to bring up a new issue, but I'm trying to clear the line for at least 15 minutes so people can get a distinction between these two meetings.

MS. MUNN: Any other very quick items for the good of the order?

(no response)

MS. MUNN: Otherwise, thank you very much. This has been a strenuous meeting, and we could have gone on here I know for another two hours, but we'll try to take care of this by telephone. We'll be on tap a week from yesterday. Thank you and thank you to all of you out there. We'll talk to you as soon as we can get our act together.

DR. BRANCHE: Okay, signing off for the Procedures work group meeting.

(Whereupon, the working group meeting was adjourned at 2:42 p.m.)

CERTIFICATE OF COURT REPORTER

STATE OF GEORGIA

COUNTY OF FULTON

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of Mar. 13, 2008; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 14th day of Dec., 2008.

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STEVEN RAY GREEN, CCR, CVR-CM, PNSC

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