

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 the

SEVENTEENTH MEETING

ADVISORY BOARD ON  
RADIATION AND WORKER HEALTH

VOLUME I

The verbatim transcript of the Meeting of the  
Advisory Board on Radiation and Worker Health held  
at The Westin Cincinnati, 21 East Fifth Street,  
Cincinnati, Ohio, on August 18, 2003.

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## TRANSCRIPT LEGEND

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In the following transcript (inaudible) signifies speaker failure, usually failure to use a microphone.

P A R T I C I P A N T S

(By Group, in Alphabetical Order)

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#### AGENDA SPEAKERS

Mr. David Sundin, NIOSH

Mr. Peter Turcic, DOL

Dr. Jim Neton, NIOSH

Mr. Mark Griffon, Workgroup Chair

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D.M. SCHAEFFER  
MARY SCHUBAUER-BERIGEN  
BOB TABOR  
RICHARD TOOHEY  
BRANT ULSH  
DAVID UTTERBACK



1 please register your attendance, as well, in the  
2 other registration book that's back on the table.

3 Also as is our custom, we have a number of  
4 handouts, items -- some of which are on the  
5 agenda, some of which are from previous meetings.  
6 I believe they're all on the table in the back,  
7 is my understanding, so you can peruse that table  
8 at your leisure and pick up those items that are  
9 of interest to you.

10 At this time then I'll call on Larry Elliott  
11 to make further comments and perhaps an official  
12 welcome to Cincinnati.

13 **MR. ELLIOTT:** Good afternoon, everyone. Good  
14 to see all the Board members back here in  
15 Cincinnati. Meeting 17 -- my, we've covered a  
16 lot of ground and done a lot of work, and we  
17 certainly all appreciate -- at NIOSH we all  
18 appreciate your labors and efforts.

19 I'd like to also welcome the public, and  
20 we're looking forward to a productive day-and-a-  
21 half meeting.

22 Some of the Advisory Board members attended a  
23 training session this morning in the NIOSH Taft  
24 Laboratory offices, working in our database  
25 tracking system, getting an understanding of

1 that. And the rest of the Advisory Board will  
2 finish up the same type of training on Wednesday  
3 morning, and then I believe everybody will have  
4 had a chance to benefit from that experience.

5 So we're -- again, we're glad you're here.  
6 We're looking forward to a day and a half  
7 together. And if there's anything that we can  
8 help you with or get for you or provide during  
9 your stay, don't hesitate to ask. Thanks.

10 **DR. ZIEMER:** Thank you. I did fail to  
11 mention that this new mike system, you do have to  
12 push the on/off button, and perhaps you're aware  
13 of that, but just a reminder to all the Board  
14 members as you're preparing to speak.

15 Now we have in our packet a couple of sets of  
16 minutes -- minutes -- actually three sets,  
17 minutes of meeting 14, 15 and 16. Now I need to  
18 determine whether or not the Board members are in  
19 fact ready to act upon these minutes. The Chair  
20 has gone through them carefully -- and actually  
21 I've done a lot of editing on them before they  
22 have come to you, so they are about one-half the  
23 length they originally were. You may think as  
24 you read them that I have removed all of your  
25 pertinent comments, but in fact we refer you to

1 the transcript if you want details on some items.  
2 But nevertheless, you have three sets of minutes.  
3 It's not obvious to me at this point whether or  
4 not you've actually had these in your hands long  
5 enough to review them.

6 If the Board wishes, we can defer action till  
7 tomorrow, but let me ask that question first.  
8 Are you ready to act on any or all of these  
9 minutes? Or are there any who wish to defer if  
10 you've not had a chance, those that perhaps just  
11 flew in today?

12 Mark Griffon?

13 **MR. GRIFFON:** Yeah, I'd like to defer.

14 **DR. ZIEMER:** You'd like to defer?

15 **MR. GRIFFON:** I just got them this morning,  
16 so...

17 **DR. ZIEMER:** Is there any objection to  
18 deferring the formal adoption of the minutes  
19 until our working session tomorrow?

20 (No responses)

21 There appears to be no objection, so without  
22 objection the Chair will rule that we will defer  
23 action on these minutes until our working session  
24 tomorrow. Now that's with the understanding that  
25 everyone then will read them carefully this

1 evening and be prepared for action. Thank you.

2 Incidentally, on the minutes, let me add this  
3 point, that if you have minor typographicals, you  
4 can simply pass those along to Cori. We're  
5 looking, in terms of adoption of the minutes, for  
6 significant changes in content or meaning as  
7 opposed to minor editorials.

8 Let us then move on to the next item on the  
9 agenda, which is our regular program status  
10 report. Dave Sundin is I believe on the agenda  
11 for that. Dave? Please.

12 **PROGRAM STATUS REPORT**

13 **MR. SUNDIN:** Can you hear me all right?  
14 Well, thanks, Dr. Ziemer, and I'll second Larry's  
15 welcome again to -- back to Cincinnati for I  
16 think the 14th face-to-face but 17th full Board  
17 meeting -- so who's counting?

18 I'll be presenting a brief overview of the  
19 program status and I'll follow the basic approach  
20 I've used in previous Board meetings. I'm  
21 beginning to wonder if maybe the format is being  
22 outstripped by the capabilities of our web site  
23 because as I returned from leave this week I  
24 realized that what I had put together before  
25 going on leave was already out of date. So I'll

1 try and point out where I was able to discover  
2 any significant changes in the numbers off of our  
3 web site this morning, but again, the web is  
4 certainly a very good way to keep current with  
5 many aspects of our program.

6 Well, the Department of Labor has transferred  
7 over 13,000 cases to NIOSH for dose  
8 reconstruction since we began operations in --  
9 way back in October, 2001. You can see the  
10 breakdown by years. And as you're probably well  
11 familiar by now, we're continuing to contact each  
12 and every claimant involved in a case which comes  
13 over to us, and also their authorized  
14 representatives, if any. We send an introductory  
15 letter, fact sheet, brochure on what dose  
16 reconstruction means, and a refrigerator magnet  
17 with contact information.

18 We also, of course -- and we think this is  
19 important -- identify a specific name of a public  
20 health advisor that's going to represent their  
21 interests which our case -- while their case is  
22 with us for dose reconstruction, and that's  
23 really the primary point of contact for the  
24 claimant to get personal information on the  
25 status of their claim.

1           We also introduce ORAU in this introductory  
2 letter. We explain ORAU's role in the process,  
3 and we provide the ORAU toll-free number as an  
4 additional point of contact for them to use.

5           Recently with our office move we began  
6 sending out -- have started, and maybe finished  
7 by now -- sending out a letter, an update letter,  
8 giving out our new telephone contact information  
9 in our new office spaces.

10           After we make that initial contact of course,  
11 we log the case into our computer system. We're  
12 still scanning each and every document we receive  
13 as a -- along with creating and maintaining a  
14 paper filing system. And I will say that our  
15 data management systems continue to serve us very  
16 well in this program. They're quite key to our  
17 ability to pull up a case quickly, to access it  
18 from remote locations throughout our contractor  
19 staff. And we do have a good crew of ITC  
20 specialists that are continually tweaking the  
21 system to provide us with technical solutions to  
22 problems that we -- or challenges that we  
23 confront in managing our end of the process more  
24 efficiently.

25           As you can see, the percentage of cases that

1 involve AWE employees has stayed relatively  
2 constant over time, 14 to 16 percent.

3 I tried to make this chart a little more eye-  
4 friendly than last time by showing -- this shows  
5 the trend in cases received from DOL, and this  
6 includes of course all four District Offices that  
7 submit cases to us, so I broke it down by quarter  
8 instead of month. And the number of cases peaked  
9 at around 2,800, I guess -- slightly more than  
10 2,800 in the fourth quarter of last fiscal year  
11 and has trended generally downward since then.  
12 Of course, again, as you know by now, each case  
13 file lists the verified covered sites where the  
14 Energy employees worked that the DOL has  
15 verified, and then we use that information to  
16 direct our requests for radiation exposure  
17 information to the appropriate DOE points of  
18 contact. And in many places the employee worked  
19 at several sites, and so we may need to direct  
20 our requests to several points of contact. We  
21 try and issue those requests within two weeks of  
22 getting the referral from DOL.

23 Give you a little update with where we are  
24 with requesting and receiving information from  
25 our DOE points of contact. We've sent out more

1 than 13,000 requests. This number also tends to  
2 change fairly rapidly on our web site. Those  
3 13,000 requests actually represent a smaller  
4 number of cases, representing about 11,700-  
5 something by now cases. And of course the reason  
6 for that is that certain people worked at more  
7 than one site. We've received approximately  
8 17,000 responses, and that's more than the number  
9 of requests we've sent. The most apparent reason  
10 and most common reason that we get more responses  
11 than requests is that certain DOE sites in  
12 particular send us several responses to our  
13 initial request. They will respond separately  
14 with the X-ray information, for example, from the  
15 RADCON information or the exposure information.  
16 Some sites I believe also -- we get separate  
17 requests from subcontractors that they then send  
18 us separately, so that accounts for that  
19 difference there. But the responses received  
20 represent 9,600 cases, and not all of those cases  
21 have a complete set of responses back, so we're  
22 not necessarily ready to go forward on that  
23 number.

24 About 12 percent of our requests are more  
25 than 60 days outstanding, and we do highlight

1 that information to our DOE points of contact in  
2 periodic e-mail updates. And it looked to me  
3 when I got back that one had another update -- or  
4 request -- or a status update had been sent out  
5 to the DOE points of contact last week.

6 This table profiles how many requests for  
7 personal exposure information we're waiting on  
8 from the -- or how our requests are going really  
9 for the big eight DOE offices, and how many  
10 responses we've currently received. Both ORAU  
11 and NIOSH are really continuing to work fairly  
12 closely with DOE's Office of Worker Advocacy and  
13 certainly very closely with each designated point  
14 of contact at the site to make sure that we're  
15 getting precisely the kind of exposure  
16 information we need to go forward with those  
17 reconstructions.

18 The telephone interview which is offered to  
19 each claimant to permit them to add information  
20 which may be relevant to reconstructing their  
21 radiation dose is depicted here. ORAU has made  
22 significant progress in completing telephone  
23 interviews and there are now more than 6,000 for  
24 which at least one interview has been completed.  
25 That's updated as of this morning.

1           We've conducted also several secure  
2 interviews using appropriately cleared  
3 interviewers in a secured location to address  
4 concerns that have been raised by the claimants.

5           Of course this has all run up to the punch  
6 line, I guess, because all of our work at NIOSH  
7 and ORAU is directed to getting a final dose  
8 reconstruction report back in DOL's hands. And I  
9 am happy to be able to report to you that the  
10 number of completed dose reconstructions being  
11 sent back to DOL for final adjudication is  
12 continuing to increase steadily. There've been -  
13 - there's currently nearly 12,000 cases -- or  
14 1,200 cases currently assigned to a health  
15 physicist for dose reconstruction. Draft dose  
16 reconstruction reports are in the hands of 127  
17 claimants. And as of this morning, 350 of them  
18 have been approved by the claimants and returned  
19 as final dose reconstructions to DOL. And of  
20 course that includes the complete administrative  
21 record, in addition to the dose reconstruction  
22 report.

23           I believe that when I last spoke to you -- to  
24 the full Board in Oak Ridge, the bottom number  
25 was 73, so we've made some progress since that

1 meeting. We clearly recognize that this is what  
2 people's eyes are focused on, including our own,  
3 and it continues to rise. But of course everyone  
4 wants us to rise as quickly as we can and still  
5 do our job.

6 Really, site profiles are key to our ability  
7 to complete significant numbers of dose  
8 reconstructions, and ORAU's assembled teams to  
9 develop these documents for all the major DOE and  
10 AWE sites. As you're aware, the Bethlehem Steel  
11 site profile's been approved. The Savannah River  
12 Site document has also recently been approved.  
13 Dr. Neton will provide you with more details on  
14 technical basis documents and site profiles  
15 tomorrow.

16 Claimants continue to phone us and contact us  
17 by letter and e-mail, as we want them to be able  
18 to do. The number of phone calls received in  
19 OCAS has increased substantially each quarter,  
20 although I believe it's actually leveled out this  
21 last quarter. We're currently receiving about 80  
22 calls a day -- in OCAS, anyway -- so we've  
23 responded to over 40,000 calls since October.  
24 ORAU is also now receiving and initiating a  
25 substantial number of calls, many of which are of

1 course related to the interview process.

2 Our web site continues we think to be  
3 valuable, not only to claimants, but to the  
4 general public. And we field a fair number of  
5 claimant e-mails to our OCAS in-box -- over 1,900  
6 actually e-mails have been received since the  
7 program got started. And we do try to respond to  
8 each of those in a timely manner.

9 So just to wrap it up, I'd like to draw your  
10 attention to some recent developments and  
11 accomplishments which I think are worth noting.  
12 DOE has asked that we appoint additional  
13 physicians to the physician panels to evaluate  
14 claims under Subtitle D, and we recently  
15 transmitted a list of 44 additional physicians to  
16 DOE, which brought the total number of physicians  
17 that we've appointed to 123. And we've had a  
18 number of discussions with DOE about their need  
19 for additional physicians to serve on the panels,  
20 and last week we initiated yet another call for  
21 nominations of interested and qualified  
22 physicians. So we'll soon be evaluating  
23 additional applications from people who are  
24 interested in being considered for those panels.

25 We're also interested in assisting DOE in any

1 way we can in identifying any process  
2 improvements that may make the physician panels  
3 operate more efficiently.

4 As I mentioned, the site profile teams have  
5 been staffed up and are developing data. You'll  
6 hear more about ORAU activities, including the  
7 current version of the negotiated production  
8 goals, from Dr. Toohey tomorrow, I believe.

9 A draft of the Residual Contamination Final  
10 Report, and this covers DOE, AWE and beryllium  
11 vendor facilities, has been prepared and it's  
12 undergoing review.

13 And finally, all of the OCAS staff is -- in  
14 Cincinnati, anyway -- is currently -- has  
15 recently moved into one building, the Taft  
16 Laboratory, which some of you have already been  
17 to, of course. And I think I speak for more  
18 than just myself when I say that we're all glad  
19 to be located in offices that are more proximate  
20 to each other than we were previously -- and  
21 certainly in many cases, nicer than what we were  
22 in before. And we're looking forward to the  
23 improvements in our processes that we believe  
24 this will bring, so I hope you have a chance --  
25 those of you that can -- to visit our new

1 environment during either this visit or any  
2 future visits you might have to Cincinnati.

3 So that concludes my prepared report. If you  
4 have questions, I'd be happy to try and answer  
5 them.

6 **DR. ZIEMER:** Thank you very much, David. Let  
7 me start the questioning by asking, on the  
8 physician panels has there been a sort of an  
9 upper limit number identified, either by NIOSH or  
10 DOE? The number seems to be growing. Where will  
11 the cap be?

12 **MR. SUNDIN:** DOE has requested up to 500  
13 physicians. Now our response to that was we did  
14 not believe that we could identify 500 physicians  
15 that possess the qualifications that we were  
16 looking for. And I think during subsequent  
17 discussions with DOE, it became clearer that it  
18 was pretty early in the process to be sort of  
19 working out capacity calculations based on the  
20 relatively small number of start-up claims that  
21 these newly-formed panels had seen. So I don't  
22 think we've really arrived at a consensus with  
23 DOE about the total number, but we did hear that  
24 figure sort of expressed by DOE at one point.

25 **DR. ZIEMER:** Jim has a question.

1           **DR. MELIUS:** Yeah, a few questions. One,  
2 back to the issue of receiving exposure records  
3 from the Department of Energy. If I recall right  
4 from the last time you spoke that the main  
5 problem sites were the -- I thought were the two  
6 I's, Iowa and Idaho, though I don't think Iowa's  
7 one you mentioned in -- discussion. Can you -- I  
8 notice that Idaho still seems to be a problem and  
9 I don't know what the status is of Iowa.

10           **MR. SUNDIN:** Well, Iowa's a little bit of a  
11 different site. Amarillo actually handles some  
12 of the Iowa cases that went to Pantex.

13           **DR. MELIUS:** Uh-huh.

14           **MR. SUNDIN:** But Iowa itself, we've been  
15 working hard to get an appropriate contact point  
16 that has authority to turn the records over to  
17 us, and DOE's been helpful in that process. But  
18 it turns out that the Department of Defense  
19 actually is now in a position to provide us  
20 records, so I don't know that they've begun to  
21 flow, but it looks like we've I believe removed  
22 some of the obstacles to obtaining those records  
23 that we were hearing about by just contacting the  
24 Burlington site.

25           **DR. MELIUS:** 'Cause what I recall, there were

1 a significant number of cases --

2 **MR. SUNDIN:** Yeah, it's not -- it wouldn't  
3 be, I don't --

4 **DR. MELIUS:** -- some hundreds, but --

5 **MR. SUNDIN:** -- think it would be sufficient  
6 to get them on this list. I don't know, it's  
7 around 500 probably, though.

8 **DR. MELIUS:** Okay.

9 **MR. SUNDIN:** Yeah.

10 **DR. MELIUS:** Do that. And then Idaho, what's  
11 the -- 'cause that still seems to be a fairly  
12 large number of case-- of requests that are half  
13 a year or whatever.

14 **MR. SUNDIN:** Yeah, the problem there was the  
15 need to index a rather large volume of records in  
16 a way that would permit them to retrieve records,  
17 so they've been spending a fair amount of time  
18 doing the basic indexing that apparently was not  
19 done at the time, so -- I've not sat in on any  
20 recent discussions with Iowa's -- or I mean INEEL  
21 folks, so I don't know how that's actually coming  
22 along. But once that's done, then the responses  
23 should start flowing to us, so -- go fairly  
24 smoothly.

25 **DR. MELIUS:** Okay. That -- if I understand

1 your numbers right, the backlog is still  
2 continuing to climb of cases -- at least in -- if  
3 measured by completion --

4 **MR. SUNDIN:** Sure.

5 **DR. MELIUS:** -- the case -- cases going. And  
6 my understanding also is that DOL is -- even  
7 though the number of cases coming into DOL are  
8 down, there are certainly efforts on the part of  
9 DOL to encourage more people that are eligible to  
10 file, to file, so --

11 **MR. SUNDIN:** Sure.

12 **DR. MELIUS:** -- I'm not sure we expect the  
13 down -- cases to continue to decrease, given the  
14 long history and the potential backlog. Is there  
15 some sense of -- and maybe this is more  
16 appropriate for later presentation, I'm not sure  
17 how you're set up today, but when do you expect  
18 to be at least, you know, decreasing the backlog?  
19 Right now you're not, I don't think, even keeping  
20 up with what's coming in, and it's -- and what  
21 sort of measures do you have, other than  
22 completed cases, to say that you are catching up  
23 with that? I don't remember the numbers from  
24 last time for the number of interviews done or  
25 number of dose reconstructions assigned, and I

1 don't know if that's a meaningful statistic in  
2 terms of measuring progress internally. So do  
3 you have some indicators that would say now we're  
4 getting -- going to get caught up with the  
5 backlog or catching up or we're going to get  
6 ahead of that?

7 **MR. SUNDIN:** Uh-huh. I didn't try and build  
8 that into my presentation because we are going to  
9 hear from Dr. Toohey about I think pretty much  
10 the topic you're asking --

11 **DR. MELIUS:** Okay.

12 **MR. SUNDIN:** -- that is, the plans to reduce  
13 the backlog. I will say, though, that the  
14 numbers that precede the final completed dose  
15 reconstruction have been -- if you go back and  
16 compare, there's quite a bit of improvement  
17 there. They're not the final answer, obviously,  
18 but they are a necessary step to get done. So  
19 things are lining up. I know you've probably  
20 heard this for several Board meetings, but  
21 certainly there are more and more cases that are  
22 headed toward final dose reconstruction.

23 **DR. MELIUS:** Uh-huh.

24 **MR. SUNDIN:** Technical basis documents are  
25 very, very key here, too.

1           **DR. MELIUS:** Yeah, I think I -- yeah, we  
2 talked about this last time, but I think it would  
3 be useful, both internally and as well as for the  
4 Board, to have some indicators of that that could  
5 be presented, other than final cases.

6           My final question is -- and again, this may  
7 be deferred until Jim Neton's presentation, but  
8 I'm a little bit confused by what your strategy -  
9 - overall strategy is to deal with the backlog,  
10 not process-wise, but in terms of how you're  
11 going to triage that backlog. Is it going to --  
12 for this first group, you've -- really, the large  
13 number of -- high proportion of these first 300  
14 or so cases have been really from one site and  
15 based -- based on a -- you know, a -- essentially  
16 a site profile, a dose reconstruction for that  
17 site. Are you planning to go through them by  
18 site now, based on site profiles? Is it going to  
19 be first come/first served, just based on who --  
20 who applied? I just don't see what the strategy  
21 is. Or is it some mix of that in order to deal  
22 with these numbers and do it?

23           **MR. SUNDIN:** It is a mix of that, and I think  
24 you are going to get the kind of specific  
25 information you're asking for tomorrow.

1           **DR. MELIUS:** Okay.

2           **MR. SUNDIN:** It's not -- it's not site-by-  
3 site, exactly. It's -- I guess my quick sort of  
4 overview of the process of sequencing things is  
5 we'd like to do the greatest good for the  
6 greatest number of people in the quickest amount  
7 of time, so we may not have a perfect strategy to  
8 do all of those things at once, but it's not --  
9 you know, it's intended to develop the sites  
10 where the larger numbers of claimants come from,  
11 where the data seems to be good enough to do that  
12 so that we get the kind of output that everybody  
13 wants.

14           **DR. MELIUS:** Uh-huh.

15           **MR. SUNDIN:** But I believe there's a couple  
16 of discussions, at lea-- well, at least one  
17 discussion tomorrow which will give you a lot  
18 more detail on that.

19           **DR. MELIUS:** Well, I just -- one comment is  
20 that that -- if you only do the high-number sites  
21 and the ones that are easiest to do -- not that  
22 any of them are easy -- then what happens to the  
23 people that are at a low-profile site that end up  
24 applying, you know, two years ago or whatever,  
25 and -- you know.

1           **MR. SUNDIN:** Right. Well, it is a mixed  
2 strategy, and it is an attempt at doing the best  
3 things. But there are specific focuses of  
4 activity on precisely the kind of people that --  
5 that might be forgotten under a strictly large  
6 site-oriented approach, and there are specific  
7 teams working that angle.

8           **DR. MELIUS:** Okay. I'll hold off until we  
9 hear. Okay.

10          **DR. ZIEMER:** Thank you. Wanda Munn is next,  
11 and then Roy. Okay?

12          **MS. MUNN:** I would just wonder where can the  
13 Board see the specific requirements that DOE has  
14 identified for the physicians it wants?

15          **MR. SUNDIN:** Actually, the rule lays out very  
16 minimal I think, if any, requirements on  
17 qualification of physicians. It's NIOSH's role  
18 to determine what qualifications we believe would  
19 equip a physician to operate on a physician  
20 panel. We've sent that -- it's styled as an  
21 announcement on the physician panels, which --  
22 and it contains a segment in there, evaluation  
23 criteria or words to that effect. It's been sent  
24 out to the two major occupational medicine  
25 societies. It's also on at least one list or --

1           which a lot of occ. physicians visit. We've sent  
2           it to anybody that we think might be in a  
3           position to either nominate other colleagues or  
4           submit a nomination themselves. I don't know  
5           that it's up on our web site, though. It's --

6           **MS. MUNN:** I wouldn't think it would need to  
7           be. I was just wondering where we might find it.

8           **MR. SUNDIN:** I can certainly bring a copy of  
9           that to you later today or tomorrow.

10          **MS. MUNN:** I'd appreciate that. Thank you.

11          **MR. ELLIOTT:** We can get it to all the Board  
12          members. We can send that to you.

13          **MS. MUNN:** Thank you.

14          **DR. ZIEMER:** Roy?

15          **DR. DEHART:** Thank you. Dave, on the  
16          telephone interviews, it's a voluntary activity  
17          on the part of the claimant.

18          **MR. SUNDIN:** Yes.

19          **DR. ZIEMER:** Are you having any denials? Is  
20          it significant at all? Refusals?

21          **MR. SUNDIN:** Some. I haven't been tracking  
22          that number as a specific item, but in talking to  
23          the ORAU people that are doing the interviews,  
24          they've described a few denials, but not very  
25          many.

1           **DR. DEHART:** Okay. So it's not really  
2 impacting the program as far as --

3           **MR. SUNDIN:** No.

4           **DR. ZIEMER:** -- you can judge.

5           **MR. SUNDIN:** Not -- not in my judgment, no.

6           **DR. DEHART:** I believe it was in Oak Ridge  
7 that an optimistic goal for dose reconstruction  
8 was going to be 6,000 at the end of the year. Is  
9 that still an optimistic goal?

10          **MR. SUNDIN:** It is an overly-optimistic goal,  
11 I think.

12          **DR. DEHART:** Perhaps tomorrow when we're  
13 talking more specifically --

14          **MR. SUNDIN:** Right.

15          **DR. DEHART:** -- we could get a new estimate.

16          **MR. SUNDIN:** Yes. I think that's the -- the  
17 plan is to have that information presented to you  
18 tomorrow.

19          **DR. DEHART:** We had talked a couple of  
20 meetings ago about the program for the physician  
21 panel, and it was talked about possibly having a  
22 briefing on that so that the Board could  
23 understand better what we're talking about in  
24 terms of this number.

25                 You have mentioned the number of physicians

1 who have been selected or identified to the  
2 panel, but does that include the ones who have  
3 withdrawn?

4 **MR. SUNDIN:** It does include the ones who  
5 have withdrawn, so in fact there are fewer than  
6 123 physicians that are currently available to  
7 work. But we've asked DOE for a current roster  
8 of those physicians that have no withdrawn, and  
9 also a listing of those that have received cases.  
10 And a little bit better understanding at our end  
11 is to -- what we should be looking for, what  
12 their process really entails, so I cannot tell  
13 you exactly how many have withdrawn. DOE  
14 mentioned that they'd had a handful of physicians  
15 withdraw, but I did not get the sense that it was  
16 a large number.

17 **DR. DEHART:** Okay. Thank you.

18 **DR. ZIEMER:** Mark?

19 **MR. GRIFFON:** And just a quick follow-up on  
20 the interviews, I'm wondering if you did any  
21 aggregate analysis of the interviews, the phone  
22 interviews. You have a lot of them now  
23 completed. Is there any attempt underway to do  
24 any aggregate analysis for that, possibly to feed  
25 into this worker profile database that's being

1 developed? Or is that even a -- on the radar? I  
2 don't know.

3 **MR. SUNDIN:** I'm not -- I don't believe we  
4 have any plans for aggregate -- are you talking  
5 about the content of the interviews or --

6 **MR. GRIFFON:** Yeah.

7 **MR. SUNDIN:** -- the sort of overall  
8 performance?

9 **MR. GRIFFON:** No, the content of the  
10 interviews. I imagine -- I don't recall the form  
11 itself, but I know it did have lists of isotopes  
12 and areas where people worked and --

13 **MR. SUNDIN:** Yeah.

14 **MR. GRIFFON:** -- I thought then there may be  
15 some usefulness to doing some sort of aggregate  
16 analysis of that data, but I don't know if  
17 that's...

18 **MR. SUNDIN:** I don't believe we've pushed  
19 that one down the road much at all. I mean there  
20 is a place where coworkers can be identified, and  
21 then of course we go follow up there, but that's  
22 not quite the -- what you're talking about. It's  
23 building a profile.

24 **MR. GRIFFON:** Yeah, right. Okay.

25 **DR. ZIEMER:** Rich Espinosa.

1           **MR. ESPINOSA:** On the backlog of -- the  
2 backlog of dose reconstructions, what's the --  
3 how is ORAU taking care of that? What's their  
4 plan?

5           **MR. SUNDIN:** Well, I believe the second day  
6 of the agenda has a specific presentation by Dr.  
7 Toohey, so I -- which includes -- which I believe  
8 will be covered during that session. Yeah.

9           **DR. ZIEMER:** Rich, are you okay deferring  
10 that answer till tomorrow?

11           **MR. ESPINOSA:** Yeah, I just didn't see it on  
12 the agenda.

13           **DR. ZIEMER:** Okay. Thank you. Did you have  
14 another question then, Rich? No. Okay. Then  
15 back to Jim.

16           **DR. MELIUS:** At the last meeting some  
17 discussion about the issue of some sort of  
18 interim communication to the claimants about the  
19 status of their claims or why the -- was delayed.  
20 Now you said -- you men-- you sent out a  
21 notification about the office being moved. Did  
22 that include any information on their claims or  
23 do you have plans to do some sort of update for  
24 the claimants?

25           **MR. SUNDIN:** No, we didn't include a broader

1 communication piece in that update to our contact  
2 information. We wanted to get that out to them  
3 as quickly as we could so that they could contact  
4 us when they wanted to. We have been having  
5 internal discussions involving health  
6 communication specialists about how to craft --  
7 what the message should be and how to craft it in  
8 a way that's going to be most useful to the  
9 claimant. So the plan is still live, but we've  
10 not yet put together the communication piece that  
11 we believe will work.

12 **DR. ZIEMER:** Thank you. Rich, I didn't see  
13 what -- did you put your sign by up or were --  
14 no. Okay. Okay, Jim is back.

15 **DR. MELIUS:** One other question. Staffing,  
16 where do you stand in terms of filling your  
17 positions and staffing.

18 **MR. SUNDIN:** I think we've got only one or  
19 two vacancies left -- four. Four, Larry says. I  
20 tell you, it's amazing what a week away from the  
21 office will do to your brain.

22 Rough numbers, between 40 and 45 OCAS staff  
23 now.

24 **DR. ZIEMER:** Are there any further questions  
25 then at this time?

1 (No responses)

2 Apparently not. I thank you very much,  
3 David, for that update.

4 I'm going to suggest that if Jim -- if Jim's  
5 in the room, that we go ahead with the next item  
6 before the break, which is the status of the  
7 procurement. It's not a long item. We're a  
8 little ahead of schedule. Jim Neton?

9 **MR. ELLIOTT:** You've got an old one.

10 **DR. ZIEMER:** Oh --

11 **MR. ELLIOTT:** You've got to go by the book;  
12 you've got an old one there. Pete Turcic from  
13 DOL. DOL's going to do it.

14 **DR. ZIEMER:** Dave, you think it's bad when  
15 you're out of the office. I've been on vacation,  
16 too, and I'm looking at my old agenda. So what's  
17 on the agenda here?

18 **MR. ELLIOTT:** Pete Turcic from DOL.

19 **DR. ZIEMER:** This is Cincinnati. Right?

20 **DR. MELIUS:** We were beginning to think  
21 you're out to lunch, not to vacation.

22 **DR. ZIEMER:** Thank you. Okay. Peter, wasn't  
23 meaning to overlook you. Thank you.

24 **DOL PROGRAM STATUS REPORT**

25 **MR. TURCIC:** Okay. It's a pleasure to be

1 here this afternoon and to give you an update on  
2 where the Department of Labor is on their aspects  
3 of administering the EEOICPA.

4 We believe that we have established a  
5 credible program, along with NIOSH and DOE, and  
6 we've made payments in all facets of the program  
7 now. We've made payments for beryllium, for SEC  
8 cancer and non-SEC cancer and also silicosis.  
9 We've forged good working relationships with  
10 NIOSH, Department of Justice, DOE, Social  
11 Security Administration, the contractors and the  
12 labor unions, and we try to build on that as time  
13 goes on. And we've paid out, as of last week, in  
14 -- over \$628 million in compensation benefits.

15 And we've completed initial processing -- and  
16 by initial processing, we call that either  
17 referral to NIOSH -- because we've made a  
18 decision that it was a covered illness with a  
19 covered employment -- or recommended a decision.  
20 And we've processed -- we've issued initial  
21 decisions in a little bit over 90 percent of the  
22 claims -- the -- in excess of 45,000 claims that  
23 we have received since the beginning of the  
24 program.

25 As far as administration of the program, we

1 have about 300 full-time equivalents working on  
2 the program at this time. And that does not  
3 count the contractor staff that we have working  
4 in the outreach areas.

5 The number and types of claims that we've  
6 received to date, again, we've received over  
7 45,000 claims, and we're anticipating receiving  
8 another 15,000 to 20,000 through this year. Of  
9 those, as you can see, the vast majority are  
10 cancer.

11 Beryllium sensitivity and beryllium account  
12 for about 4,000. One point there is that our  
13 claims from beryllium vendors or subcontractors  
14 of beryllium vendors have dropped off to almost  
15 nothing. You know, I think we've received maybe  
16 40 claims from beryllium vendors, so we're going  
17 to be doing a lot of focusing this year on  
18 outreach efforts and try to get to, you know,  
19 some of these pockets of claimants that we have  
20 not heard from. And RECA and in other, about  
21 22,000 claims.

22 And that's just a breakdown showing the total  
23 claims and the types of -- as you can see, vast  
24 majority are cancer and other. The breakdown has  
25 been holding pretty steady now, with about 57

1 percent of our claims coming from survivors as  
2 opposed to employees.

3 And the status of our cases, the current  
4 cases, we have -- we've referred 13,700 for dose  
5 reconstruction. We currently have a little bit  
6 over 1,800 that are pending a final decision.  
7 That means that there's been a recommended  
8 decision and we're either waiting or in the  
9 process of writing a final decision, waiting to  
10 see if the claimant either objects to the  
11 decision and asks for a hearing or a review of  
12 the written record or waives their objections.

13 Final decisions in almost 18,000 cases, and  
14 we're currently processing -- our working  
15 inventory seems to be hanging around 4,000 cases.  
16 That would be the time period, you know, from the  
17 time the case is filed until we get a initial  
18 decision.

19 And again, the -- by far, our denials. Most  
20 of our denials are still for non-covered  
21 conditions, and these are just some of the major  
22 ones. And this has been holding pretty steady --  
23 other lung conditions, other heart failure, no  
24 condition reported. That seems to have climbed a  
25 lot recently where we're getting a number of

1 claims where -- mostly from facilities that  
2 people think are either going to be closed soon  
3 or a contractor change or whatever, and a lot of  
4 people, when they're retiring, they're just  
5 filing a claim. And a lot of them are no covered  
6 conditions, so we want to do some outreach in  
7 that area to try to get the word out that there  
8 is no statute of limitations. People don't have  
9 to do that. They're not buying their place in --  
10 you know, setting a place in time, so...

11 Of the final decisions, again, not -- nearly  
12 9,500 to approve, 12,500 to deny. Again, most  
13 common reason for denying is non-covered  
14 condition.

15 The recommended decisions, again, 9,700 for  
16 approvals, 14,600 for denials, over 13,000 in for  
17 dose reconstruction. We made 8,500 payments in  
18 excess of \$628 million and we've paid about --  
19 over \$14 million in medical benefits -- and  
20 that's starting to really increase now that  
21 people are starting to have their bills paid by  
22 us, their medical bills, as opposed to some other  
23 insurance.

24 And the breakdown on denials of the final  
25 decisions, again -- they're the ones that approve

1 of the denials. As you can see, of the 12,500  
2 denials, over 8,000 are for non-covered  
3 conditions. And everything else, you know, drops  
4 down substantially beyond that. And that just  
5 shows about 57 percent of the final decisions are  
6 being denied at this point in time.

7 One of the things that we track in our goals  
8 that we've -- performance goals that we've  
9 established for our District Offices is we've set  
10 -- we have two different time frames for reaching  
11 that initial decision. One for cases that  
12 involve an AWE, a beryllium vendor or a DOE  
13 subcontractor, which our goal there is 180 days  
14 to have 75 percent of the cases completed within  
15 180 days, initial decision. And then 120 days  
16 for those that are for a -- from a DOE facility.

17 To show what we've done this year, because  
18 what we did was we focused early on this fiscal  
19 year to eliminate -- and our goal was to  
20 eliminate our backlog, so we have completely  
21 eliminated any backlog of cases and we're now  
22 basically working on a working inventory. As you  
23 can see, the average time for the first quarter  
24 when we were getting that first group that, you  
25 know -- we had 18,000 claims, you know, on July

1 31st. Once we worked through all that, the first  
2 quarter of this year our average time was about  
3 242 days. Went down in the second quarter down  
4 to 212, and now we're operating and getting an  
5 initial decision in about 142 days.

6 For DOE facilities, again, very similar.  
7 Started out 176 days. We're down to in about 64  
8 days. You know, if we get a employment  
9 verification and -- on the average, we are  
10 getting that case either to NIOSH or a  
11 recommended decision within about 64 days on the  
12 average.

13 And the status of the claims, again, the case  
14 is returned from NIOSH -- and these are slightly  
15 different than the numbers because this is  
16 anything that comes back, for whatever reason.  
17 We start out with 293 -- and the time frames  
18 could be different, too -- had completed dose  
19 reconstructions and 162 dose reconstruction was  
20 not required. That could have been like a CLL  
21 case or some other issue. Or maybe we found out  
22 that it wasn't ready to go to NIOSH, we found  
23 more employment or, in several cases, we got  
24 information back from National Cancer Institute  
25 that something that originally we weren't calling

1 one of the specified cancers are now considered a  
2 specified cancer.

3 Recommended decisions, we have -- or  
4 acceptances in 115 of those and 147 are denials,  
5 recommended denials; and final decisions, 100 to  
6 accept and -- what was that -- and 38 to deny.

7 Our plans -- I guess I shouldn't have put  
8 that number up, but -- the plans to complete the  
9 approximately 4,000 dose reconstructions that  
10 ORAU is projecting that they will complete this  
11 year, our goal and what we hold our districts to  
12 is that we want to have -- we give them on the  
13 average of 21 days in order to have -- once we  
14 receive a dose reconstruction back from NIOSH, to  
15 have a recommended decision. And then the time  
16 from that would be the same, you know, depending  
17 on if it was -- you know, if the claimant is  
18 asking for a review of the record or a hearing,  
19 then that -- actually that time can change  
20 significantly.

21 And we have committed and have come up with a  
22 plan where we will shift cases. I mean because  
23 of the way they're going to come back, they're  
24 going to come back in large numbers from a  
25 certain facility, so like for example, when

1 Savannah River -- a big in-rush of Savannah River  
2 cases hit our Jacksonville office, what we have  
3 done, we have paired up each of our District  
4 Offices. If we get an overload, we will move  
5 cases for a recommended decision -- to do the  
6 probability of causation, write the recommended  
7 decision and, you know, share it between two  
8 District Offices, and then the case would go back  
9 and be administered in the original District  
10 Office. So that will be seamless to the -- you  
11 know, to the claimant.

12 Just to give you some idea of some of the --  
13 you know, in the Cleveland area, our Cleveland  
14 District Office, here are the major -- the major  
15 sites that our Cleveland District Office handles.  
16 As you can see, the area that it -- the  
17 geographic area that it covers, it's most-- you  
18 know, mostly AWEs and beryllium vendors for the  
19 Cleveland office. And again, these are just a  
20 number of -- the percentage, the worker  
21 population and the percentage of claims. As you  
22 can see, they're very low from this in the  
23 Cleveland District Office.

24 The work sites in Ohio, the status -- total  
25 claims, 3,400 and 1,000 for dose reconstruction,

1 with about 1,500 recommended decisions and 1,300  
2 final decisions. And we've paid about \$105  
3 million in the state of Ohio. And the case load  
4 from Ohio, again, about 95 cases are waiting a  
5 final decision and there's about 968 that are  
6 under process from the state of Ohio. And the  
7 types of claims are pretty consistent again. You  
8 know, over 2,300 are cancer, vast majority are  
9 the cancer claims. Chronic beryllium disease,  
10 here -- you know, in Ohio we have a significant  
11 amount. The lion's share of the beryllium cases  
12 are out of the Cleveland District Office.

13 **DR. ZIEMER:** All right. Thank you. Thank  
14 you very much, Peter. Our first question will  
15 come from Dr. Roessler.

16 **DR. ROESSLER:** I think just for the record,  
17 let's go back to your second slide. I think you  
18 have a very large mistake on it --

19 **DR. ZIEMER:** A million million?

20 **DR. ROESSLER:** Yeah. I think that should be  
21 corrected. You've paid out a little over \$628  
22 million --

23 **MR. TURCIC:** Million.

24 **DR. ROESSLER:** -- but not million million.

25 **MR. TURCIC:** Yeah.

1           **DR. ROESSLER:** Yeah.

2           **MR. TURCIC:** All right. Thank you.

3           **DR. ZIEMER:** Roy DeHart.

4           **DR. DEHART:** Thank you. When you were  
5 discussing beryllium sensitivity --

6           **MR. TURCIC:** Uh-huh.

7           **DR. DEHART:** -- if I'm correct, that does not  
8 pay out any -- any bonus or pay or -- it only  
9 implies that there will be ongoing medical  
10 evaluations.

11           **MR. TURCIC:** That's correct.

12           **DR. DEHART:** Is that correct?

13           **MR. TURCIC:** That's correct.

14           **DR. ZIEMER:** Jim, you have a question?

15           **DR. MELIUS:** Yeah, I believe when Shelby  
16 spoke to us at the last -- I think it was at the  
17 last meeting -- in Oak Ridge, he mentioned that  
18 the amount being paid out for medical  
19 reimbursement's been relatively small and that  
20 you were trying to take steps to encourage that,  
21 as well as sort of clarify this issue about non-  
22 covered conditions and so forth. Can you speak a  
23 little bit about your outreach on those types of  
24 issues, what you're doing?

25           **MR. TURCIC:** Yeah, we just had one area that

1 we were having a big problem with that was up in  
2 Alaska and we were just up in Alaska and we found  
3 that some of the problem was with the pharmacies.  
4 Pharmacies didn't want to take our card and so  
5 we've been doing some outreach there. In fact,  
6 we'll be back up there at the end of the month  
7 meeting with the medical providers and trying to  
8 get more of them signed up.

9 The other things that we have done is that  
10 we'll go into an area and we recently did one in  
11 Paducah, Kentucky with the union, the -- and in  
12 an effort to try to get more people, more  
13 claimants, to have their bills billed to us.  
14 That was a -- that's a big issue. So we're --  
15 we've also done a mailing to everyone who is  
16 entitled to medical benefits and put together a  
17 packet so that -- of information with cards in it  
18 so they can pull it out and have a handy way of  
19 access to our -- our medical provid-- bill-  
20 paying, phone numbers and assistance.

21 **DR. ZIEMER:** Roy DeHart again.

22 **DR. DEHART:** A follow-up question on that.  
23 What fee structure are you using to reimburse  
24 providers and the pharmacy? Are you using  
25 Medicare or some other kind of --



1           Thank you very much, Peter. Appreciate the  
2 update.

3           Now perhaps we could go ahead with Jim Neton,  
4 if Jim is here. We're still ahead of schedule.  
5 Jim, are you here?

6           **DR. NETON:** My and Mark's presentations sort  
7 of go together, though. I don't know if it might  
8 be --

9           **DR. ZIEMER:** Okay.

10           (Whereupon, Dr. Neton and Mr. Griffon  
11 discussed the order of their presentations with  
12 Dr. Ziemer, off the record.)

13           **DR. ZIEMER:** The Chair will rule that it's  
14 time for a break, and so -- but we will confine  
15 the break again to -- we'll let it go 20 minutes.  
16 How does that sound? 'Cause they do have to do a  
17 little discussion during the break. So 20-minute  
18 break and then we'll reconvene. Thank you.

19           (Whereupon, a recess was taken.)

20           **DR. ZIEMER:** We're going to call the meeting  
21 back to order. As you know, the Board has been  
22 searching for a contractor to assist in the  
23 review process -- that is, the audit, as it were  
24 -- of dose reconstructions. And Jim Neton is  
25 going to report on the status of that

1 procurement, and then we'll follow that with a  
2 discussion on the task order development. Okay?  
3 Jim.

4 **STATUS OF PROCUREMENT**

5 **DR. NETON:** Okay. Thank you, Dr. Ziemer.  
6 I'd like to preface my remarks by saying I can  
7 only discuss this to the extent the procurement  
8 regulations allow, so if I seem -- appear to be  
9 sketchy, that's because that's what the Federal  
10 Acquisitions Regulations require.

11 I am happy to report that we did receive more  
12 than one proposal for the task order contract, so  
13 that allowed us to move forward for an  
14 evaluation. We assembled a technical evaluation  
15 panel. That panel has met twice by  
16 teleconference to do the technical evaluation and  
17 scoring of the proposals that we received. Based  
18 on that scoring, we established -- with input  
19 from our Pittsburgh grants office -- a  
20 competitive range. And the proposals that made  
21 the competitive range we went forward with and  
22 did a request for a past-performance evaluation.  
23 So we're at the past-performance evaluation  
24 stage.

25 I just got off the phone with our secretaries

1 over at the Taft Building and we have received  
2 the past-performance evaluations for the  
3 proposals that remain in the competitive range,  
4 so they're being FedExed to the technical  
5 evaluation panel members this afternoon.

6 We can review those past-performance  
7 proposals, and once we do that, re-evaluate or  
8 re-establish the competitive range for the  
9 proposals. And at the same time, we're shipping  
10 out the cost proposals and we will then review  
11 the cost proposals and make our recommendation to  
12 procurement as to our selection based on  
13 technical merit.

14 We establish a score based on technical  
15 merit, and then we put feedback in on the cost  
16 proposals to procurement. So we're at that  
17 stage.

18 We should be able to wrap this -- well, it's  
19 possible this could be wrapped up fairly quickly  
20 if we do not enter negotiations, either singular  
21 or multiple, with vendors. So we're very close.  
22 It could be within a matter of -- we may be able  
23 to meet or original projected time line, which is  
24 by the end of this fiscal year. So that's where  
25 we're at.

1           If there's any questions, I can answer them  
2 at this time. Otherwise, I think Mark is  
3 prepared to talk about the fleshing-out of the  
4 task orders.

5           **DR. ZIEMER:** Any questions?

6                               (No responses)

7           Okay. Thank you, Jim, for that status  
8 report. Then Mark, if you'll proceed then with  
9 the task order development. And there is a  
10 handout. It's been sent around the table. There  
11 are copies for the public's -- perhaps on the  
12 table by now. It's a single-sheet Power Point  
13 handout.

14                               (Pause)

15           **DOSE RECONSTRUCTION WORKGROUP AND BOARD DISCUSSION TO**  
16                               **DEVELOP TASK ORDER**

17           **MR. GRIFFON:** Get my refresher training on  
18 the system here. You'll notice that I -- I tend  
19 to use the black and white overheads 'cause I  
20 usually develop these on the plane ride out here,  
21 so no fancy colors with this.

22           This is just a status report on where our  
23 working group is. The tasks -- we developed  
24 draft procedures for the review process, and  
25 that's how we're going to go forward with the

1 individual case reviews. And you may not  
2 remember this, but we had a procedure -- on the  
3 next slide I'll go through some of what that  
4 procedure contained -- on how we were going to go  
5 forward with the individual case reviews.  
6 Actually Cori's making copies right now for the  
7 Board and we're going to give that out as  
8 homework here. I'd really like to get comments  
9 from the Board tomorrow on that procedure, you  
10 know, so mark it up -- read through it tonight,  
11 and if you can, mark it up. Now that we know a  
12 little more of how this is going forward, I think  
13 we'll probably be modifying that a little bit.

14 The second thing was the procedure for the  
15 selection process, and I sort of separated those  
16 out, review versus the selection. And if you  
17 remember, last meeting I brought up Excel  
18 spreadsheet, which was a little busy as an  
19 overhead, I must admit. But it was the way we're  
20 going to sort of matrix how we were going to  
21 select cases -- by site, by cancer type, by  
22 radiation type, et cetera -- and how we were sort  
23 of going to fill in these boxes as we went along,  
24 depending on what cases were in the hopper, what  
25 cases were completed, and going through the whole

1 process that would drive how we were going to  
2 fill this matrix in, with the ultimate goal of  
3 around two and a half percent of the overall  
4 cases we were going to do -- we were going to  
5 review about two and a half percent of the  
6 overall cases.

7 And then the last thing was develop  
8 individual task orders, and I think these were at  
9 the back table, as well as handed out to the  
10 Board members. When you first came in you  
11 probably noticed those few pages. And we had  
12 drafted these at the last meeting and we got some  
13 feedback and reformatting from NIOSH on these.  
14 And the hope is that we'll get these tasks  
15 completed prior -- or right around when the  
16 contract is awarded so we can get the tasks out  
17 right away to the contractor or contractors to  
18 bid on.

19 And the two tasks right now that we have are  
20 individual dose reconstruction review, basic and  
21 advanced; and the methods review, the procedures  
22 review. Okay?

23 So this is that first -- the procedure for  
24 the dose reconstruction review process, some of  
25 what it contains. We have a section on how we're

1 going to select cases in there, how we're going  
2 to designate Board members for the review, and  
3 the distribution of the data, interaction between  
4 the contractors and the Board, the report  
5 generation -- if you're a member, we also had  
6 some draft reports; three different levels, the  
7 individual reports, the summary reports and then  
8 the Board report to HHS. We talked about three  
9 different sort of levels of reporting. And then  
10 the Board recommendations to NIOSH regarding  
11 individual cases and also aggregate -- you know,  
12 do we have general findings from what we've  
13 reviewed.

14 And then the case selection procedure, we  
15 just briefly had our working group meet over the  
16 break. We're going to reconvene tomorrow  
17 morning. I've -- I've started to structure  
18 another procedure on this along -- to go along  
19 with that matrix that I -- that I put up at last  
20 meeting and -- just to have some language on --  
21 and some of the things we want to consider in  
22 this are the case availability. I think that --  
23 obviously we've got to understand a little bit  
24 about how NIOSH is -- is proceeding so we know  
25 what cases might be coming avail-- you know,

1 coming up. We're not going to review cases until  
2 they're completed, and so we have to look at case  
3 availability.

4 The case selection criteria we're going to  
5 outline in the -- in this procedure, as well;  
6 sampling strategy. The case assignment process,  
7 I think we have to -- you know, there's some  
8 logistics involved here. There's also a question  
9 about the Advisory Board's conflicts of interest,  
10 so we have to figure out first of all who wants  
11 to work on different cases and then who can work  
12 on certain cases, so -- and then -- and how they  
13 will work with the contractor.

14 And then the tracking process, and again,  
15 some things to think about here are, you know,  
16 who's going to do the tracking? Are we going to  
17 have an established subcommittee or working  
18 group? Will NIOSH do the tracking for the Board?  
19 You know, how is that going to work? And also  
20 along with this, defining the scope of the -- of  
21 the individual task. That might actually be  
22 misplaced a little, but I'll come up to this  
23 point again. The idea here is that as -- as  
24 these tasks are released to the contractor,  
25 they're going to come back with a proposed scope

1 of work. And the question here is is the Board's  
2 responsibilities versus NIOSH's responsibilities.  
3 NIOSH is the contractor. We as a Board I think  
4 want to control it to some extent, the scope of  
5 work. Maybe not the financials of the contract,  
6 but at least the scope of what the contractor  
7 will be doing. So we have to figure out how --  
8 where those lines of responsibility lie.

9 Okay. And this --

10 **DR. ZIEMER:** Mark, let me interrupt a minute.  
11 Might I ask if the -- if the Board members have  
12 questions as you proceed --

13 **MR. GRIFFON:** Sure.

14 **DR. ZIEMER:** -- would you like them to raise  
15 them at that point rather than wait till the end?

16 **MR. GRIFFON:** That's fine, yeah. Yeah.

17 **DR. ZIEMER:** Then let me ask --

18 **MR. GRIFFON:** That means you have a question.

19 **DR. ZIEMER:** -- a question. On the tracking  
20 process --

21 **MR. GRIFFON:** Yeah.

22 **DR. ZIEMER:** -- is there any reason why the  
23 Board's contractor wouldn't do the tracking that  
24 you're talking about versus NIOSH itself? What's  
25 -- we're just tracking the cases that the Board

1 is reviewing here. Right? Is that what you're -  
2 -

3 **MR. GRIFFON:** We're tracking the cases that  
4 we're reviewing, but also we're tracking them  
5 against the matrix that we've established up  
6 front. So say we wanted to do 30 Savannah River  
7 cases overall, but we also wanted certain other  
8 criteria to be met. So you know, as we fill in  
9 those blanks -- and we may not do all 30 Savannah  
10 River cases, you know, up front, so -- you know,  
11 it's tracking sort of what we've done versus what  
12 were -- our goal is. And I guess the contractor  
13 could be tasked with that responsibility, too,  
14 yeah -- yeah, so...

15 So this is the task orders, as I -- I think I  
16 mentioned this already, that two of the task  
17 orders have been drafted, the methods review and  
18 the individual dose reconstruction review task  
19 orders. A lot of the language was lifted right  
20 from the original contract that we -- the  
21 proposal that we let out. The one that I think  
22 we need to -- and we're going to work on more  
23 tomorrow morning with our working group is the  
24 site profile task. And that -- right now we have  
25 sort of very broad language about what we mean by

1 site profile review, and I think we need to fine-  
2 tune some of that. We're going to work on that  
3 and try to get at least a rough draft to the full  
4 Board tomorrow morning on that.

5 Like the commitments I'm making for us?  
6 Good.

7 Discussion items. Some of these were at our  
8 last meeting, too, and I think we touched on some  
9 of them. But I think we certainly haven't  
10 resolved all of them.

11 The Board and the contractor access to data,  
12 and by this I mean, you know, NIOSH data as well  
13 as possibly other data -- DOE data. There are  
14 some questions that have been raised in previous  
15 meetings about Privacy Act issues, whether we can  
16 get this data on CDs, so I think we -- we need to  
17 explore that and -- you know, this was also kind  
18 of a question for NIOSH, if there was an update  
19 on that, on those questions.

20 The Board and the contractor access to site  
21 personnel and/or NIOSH staff. And site  
22 personnel, I mean DOE or -- primarily DOE site  
23 personnel and NIOSH staff that worked on either  
24 the site profile or on the individual dose  
25 reconstructions, whether they can go back to

1           those resources and talk to them about  
2           assumptions, et cetera, in the cases.

3           This one had a lot of discussion in the early  
4           going. We dropped this from our original  
5           proposal, but the Board and contractor access to  
6           claimants for follow-up. And I think we really  
7           need to -- we said after we put the contract out  
8           we'd bring this up again, and I think we need to  
9           discuss it more, whether the Board feels it's  
10          necessary to do follow-up with the claimants  
11          about their phone interviews and the issues  
12          surrounding that question, I guess I think we  
13          need to discuss as a Board. And also the -- what  
14          would it take to allow the Board to do that. So  
15          that one I think we need to -- further discussion  
16          on that.

17          And then the Board recommendations from  
18          individual case review reports and summary  
19          reports. This really is the -- I think this goes  
20          into that -- some of those draft reports we  
21          discussed. How do we communicate this to NIOSH,  
22          to HHS, for the aggregate findings as well as for  
23          individual case findings. I think when we're  
24          talking about individual case findings, it's more  
25          of a case where it would have made a difference

1 between a favorable claim versus unfavorable  
2 claim.

3 And then establish a process for the Board to  
4 review contractor's response to individual tasks.  
5 That's what I -- what I raised a few minutes ago,  
6 the question of -- maybe not very clearly stated  
7 there, but the question of who -- or where the  
8 lines of responsibility for defining -- or  
9 refining the scope that the contractor agrees to  
10 do under a certain task, so -- so if they bid on  
11 the methods and procedures review but their  
12 language -- some might feel is broader than was  
13 in the original proposal, how do we refin-- you  
14 know, who has the responsibility of refining that  
15 language and making sure it's -- you know, and  
16 where is the line. I know that NIOSH is the  
17 primary contractor, but I think that we on the  
18 Board have a interest in making sure we keep the  
19 technical scope appropriate.

20 And I think that's it.

21 **DR. ZIEMER:** Okay. Thanks, Mark. Let me ask  
22 if other members of the subgroup want to add  
23 anything or... Yes, Roy?

24 **DR. DEHART:** It's not really an add, but  
25 Mark, do you have any feel about when we're going

1 to have -- have to have this information specific  
2 so that when the bids are complete and everything  
3 is done, when we're going to get this forwarded  
4 to the contractor and start this kind of review?

5 **DR. ZIEMER:** Jim Neton can give us an  
6 estimate of when we might be ready with a con--  
7 the earliest date we could have a contract in  
8 hand sort of thing.

9 **DR. NETON:** Boy, I wish Martha -- Martha  
10 DiMuzio were here, she could probably answer that  
11 better than I. But if all goes and we don't end  
12 up going through negotiations with the contractor  
13 -- I mean we review the past-performance  
14 proposals and the pricing -- cost proposals and  
15 we just select a vendor, I mean that could happen  
16 in a matter of a week or two. Matter of fact, I  
17 think our responses are requested back by next  
18 Monday to the contracts. So I don't know. I  
19 can't speak for them how long it would take them  
20 to process and get an award out the door, but I  
21 would think it would be a matter of several weeks  
22 after that. And upon award of the contract, I  
23 see no reason why we couldn't issue a task order,  
24 particularly if it's --

25 **MR. GRIFFON:** So you're talking --

1           **DR. NETON:** -- going to be very soon.

2           **MR. GRIFFON:** -- maybe early October or --

3           **DR. NETON:** Yeah, I would think early  
4           October. And Larry, you might have a better  
5           sense, but I would see -- it's possible. I can't  
6           promise that.

7           **MR. GRIFFON:** Yeah, and that's why -- I think  
8           we have two tasks sort of in rough draft form, if  
9           folks can look at those tonight, as well, and  
10          give some feedback on that. I have already got  
11          some comments from NIOSH. I'm going to take  
12          those comments into account -- modify it a little  
13          bit and bring a new draft tomorrow as well on  
14          those, and those are covering the individual,  
15          basic and advanced reviews, as well as the  
16          methods and procedures review, something to get  
17          started on. I think I really want to get a rough  
18          draft of the site profile review task out, as  
19          well, so --

20          **DR. ZIEMER:** Larry has an additional comment  
21          here.

22          **MR. ELLIOTT:** I think that October is a good  
23          date for you to target your efforts toward. I  
24          fully expect that the contract will be awarded by  
25          then. That's what we're all striving for.

1 I think also that as you think about  
2 developing these tasks you should add a task for  
3 their contractor to do the tracking, the  
4 monitoring assignment. That's not something  
5 NIOSH should do nor wants to do. We have plenty  
6 of work of our own. We could certainly help, but  
7 I don't want to take that on. And I think it's  
8 best if your contractor does that for you, but  
9 that would have to be done under a task.

10 The other thing I need some clarification on  
11 in my own mind is -- you were talking just before  
12 your concluding remarks about this defining the  
13 scope issue. I'm lost on that. The scope of  
14 work is defined in the award. Are you talking  
15 about scope within the task?

16 **MR. GRIFFON:** Yes.

17 **MR. ELLIOTT:** Okay. That helps me understand  
18 then. Okay.

19 **MR. GRIFFON:** I'm sorry.

20 **MR. ELLIOTT:** 'Cause you mentioned something  
21 about some proposals seemed to be broad or  
22 overly-broad beyond maybe what you're thinking of  
23 in a task scope, I guess.

24 **MR. GRIFFON:** No, no, no. No, no, no, I said  
25 -- I said if -- if a proposal to a task was

1 broader than we thought the task entailed -- in  
2 other words, the contractor went beyond --

3 **MR. ELLIOTT:** Okay, I understand. To talk  
4 process here, the contract's awarded let's say  
5 first of October. You're going to need to think  
6 about having a meeting with your contractor to  
7 present your tasks. And then it -- usually the  
8 way this business is done, you give the  
9 contractor two weeks to prepare a proposal  
10 against that task. You evaluate the proposal,  
11 and then there's -- if there's any negotiating  
12 that needs to be done at that point, you do it  
13 and you refine either the task or the --  
14 typically what's refined is the proposal against  
15 the task, not the task itself.

16 **MR. GRIFFON:** Right.

17 **MR. ELLIOTT:** So you refine the proposal to  
18 where you want it to be.

19 **MR. GRIFFON:** That's what I meant. Probably  
20 not very well-stated, but that's what I meant.

21 **MR. ELLIOTT:** You're in the driver's seat on  
22 that, not NIOSH. That's this Board. So as you  
23 think about the process, you're going to have to  
24 think about the timing. You're going to have to  
25 think about whether you can do this without the

1 full Board. And we're going to have to think  
2 along with you about whether or not some of this  
3 needs to be done in closed session. So there's a  
4 lot of work to be done in preparing the -- just  
5 to issue these tasks in a final form.

6 **MR. GRIFFON:** Right.

7 **MR. ELLIOTT:** So -- and we're here and we're  
8 glad to help you do that. But I just -- I want  
9 you to all think in that -- those kind of  
10 frameworks.

11 **DR. ZIEMER:** Thank you for that  
12 clarification. And along those lines, we may  
13 need in fact to get opinion of counsel on the  
14 extent to which this Board can delegate some of  
15 those activities to a working group, for example  
16 -- for example, to do an evaluation or to sit  
17 down with a contractor or whether in fact that  
18 needs to be the whole Board in open session or in  
19 executive session.

20 **MR. GRIFFON:** Right.

21 **DR. ZIEMER:** And I don't know if this is  
22 something that we might ask legal counsel to take  
23 a look at, at least give us an early heads-up on  
24 what might be coming in that regard. Okay?

25 Anything else at this point, Mark? You're

1 going to have a distribution for tonight's  
2 homework assignment, is that what we understood?

3 **MR. GRIFFON:** That's right. That's right.

4 **DR. ZIEMER:** Or does everybody have a copy  
5 right now?

6 **MR. GRIFFON:** I mean I don't know if now is  
7 the time, but I think we need a discussion on the  
8 question as to whether to re-interview, to have  
9 the Board or the contractor get access to the  
10 claimants.

11 **DR. ZIEMER:** I'm -- let me give an early  
12 answer to that, and this is not so much an answer  
13 as an idea that -- I'm wondering if we would have  
14 a better feel for whether or not -- well, before  
15 we get into an extensive debate on this, 'cause  
16 we had extensive debate before on that issue.  
17 When we get into the review process, it might  
18 become evident one way or the other whether or  
19 not such interviews would in fact be needed or  
20 helpful. We may find that -- from the  
21 established record and other documentation that  
22 such interviews would not be required or would be  
23 very important, depending on what we find. So  
24 I'm not sure that we necessarily need to reach  
25 conclusion on that right now. Is there any

1 reason we need to come to closure on that at this  
2 point? 'Cause it could be handled in a task at  
3 some point later. Jim?

4 **DR. MELIUS:** If I recall right, and this goes  
5 back several months when we first had some  
6 discussion of this issue, I think we deferred it  
7 a little bit until we were -- those of us who had  
8 not seen the database system and had not seen the  
9 records had had an opportunity to look at them.  
10 Now some of us had our training this morning, a  
11 number of others are having -- that's certainly  
12 one of the things I spent some time looking at  
13 was trying to get a handle was based on the  
14 interview record that's available in the NIOSH  
15 database, which is a summary document of the  
16 interview -- electronic summary. To what extent  
17 is that -- is that an adequate document for -- to  
18 do a -- you know, a dose review. And I think for  
19 the other group that's having a -- their training  
20 on Wednesday morning, I think that's something  
21 they should also look at 'cause I think -- I  
22 don't think we -- I'm very hesitant to wait until  
23 we get part-way through the review process  
24 because I would be -- I think it would put NIOSH  
25 and everyone in a bad position to have a partial

1 review from the Board. The Board -- the dose  
2 reconstructions are fine, but we have questions  
3 about the adequacy of our review because we  
4 didn't -- weren't able to re-interview and now we  
5 need to re-interview. I think to the extent that  
6 if we can deal with the issue before we start the  
7 review process, I think it would be better for  
8 everyone -- for the process itself and for the  
9 credibility of our review, rather than having  
10 something that we've reviewed it and -- but we  
11 still need to go back and look at this. Now --  
12 now our review is never going to be complete, you  
13 know, because there's going to be more cases to  
14 review and -- as the program goes on. But at the  
15 same time I think to the extent that we can we  
16 ought to try to make the process as complete and  
17 comprehensive as possible up front. Then if we  
18 have to modify it later, fine. But I -- I would  
19 hesitate on just deferring until we're several  
20 months into the review process and then making a  
21 decision like that.

22 I think we also have to remember that if we  
23 are to add a follow-up -- some sort of follow-up  
24 interview or contact with the claimants, that's  
25 going to have to go to OMB for approval. There's

1 a fair amount of bureaucracy and paperwork to do  
2 that and a fair amount of time. So we're talking  
3 about something that, you know, realistically is  
4 going to take some months to do, even -- once  
5 we've agreed on what should be done and how to  
6 complete it. So I think -- be another reason to  
7 try to, if we can, come to some conclusion on  
8 that as soon as possible.

9 **DR. ZIEMER:** Any other comments on that  
10 issue? Mark?

11 **MR. GRIFFON:** And just the other reason for  
12 considering it up front instead of waiting is  
13 that at several meetings now we've heard concerns  
14 about these phone interviews from -- from  
15 claimants or representatives of claimants. And -  
16 - you know, so I think if we're hearing from the  
17 public that they're concerned that the interview  
18 didn't capture everything that they -- and I know  
19 they have opportunity to respond and correct the  
20 record, but we've certainly heard that on  
21 testimony a number of times, so I -- you know, I  
22 don't know that we really need to wait. And the  
23 other concern would be the delay on getting it  
24 through the system, the bureaucracy, to get it --  
25 even approval to do it, so...

1           **DR. ZIEMER:** Any other comments, either on  
2 that issue or related matters? Jim?

3           **DR. MELIUS:** I'm just thinking in terms of  
4 how we're going to work and work through this  
5 process, and even more than about the interview  
6 process, I'm concerned that we've got to really  
7 sort of -- lot of issues left out there in terms  
8 of how we're going to proceed in terms of  
9 developing a procedure and a schedule for doing  
10 this. And I don't know what the plans are for in  
11 terms of further discussions, but to the extent  
12 that the work group can try to figure out some of  
13 these legal issues and procurement issues and  
14 figure out what needs to be done and, you know,  
15 what we need to do in terms of subcommittees  
16 meeting and so forth, I think it's -- we need to  
17 accomplish as much of that as possible by the end  
18 of our meeting tomorrow. And I don't know if  
19 NIOSH counsel's available to meet or speak about  
20 some of these issues or what we need to do in  
21 terms of procurement, but seems to me if we  
22 don't, either we have to -- if we don't get a  
23 good process set up and understood, that we could  
24 end up either having to meet as a Board every  
25 other week for a while or we're going to have to,

1 you know -- this is going to get stretched out  
2 for a very long time, which I don't think serves  
3 the process well.

4 **DR. ZIEMER:** Other comments? Wanda?

5 **MS. MUNN:** I continue to be concerned over  
6 the concept of re-interviews, especially by this  
7 Board or some portion of this Board, as being  
8 some kind of next-step -- some kind of appeal  
9 process, which I believe we've all agreed -- I  
10 think we agreed that that was not going to be the  
11 case at all. I'm very concerned that as we move  
12 down this pathway, it is very clear that this is  
13 not an appeal process and that it is in fact a  
14 quality assurance process for reviews that have  
15 been done, that are selected in a random way, not  
16 because of any additional appeal or any  
17 additional action on the part of the claimant.  
18 Whether such clarification needs to be very  
19 clearly spelled out in the statement of work is  
20 another issue to me, but as we proceed down this  
21 path, I would hope that all the members of the  
22 Board would keep that aspect of what we're doing  
23 here very clearly in mind, because it's a major  
24 concern to me. How things are observed from the  
25 claimant point of view is key, I think, here.

1           **DR. ZIEMER:** Thank you. Other comments? Gen  
2           Roessler.

3           **DR. ROESSLER:** Are you reopening discussion  
4           of whether it should be done or shouldn't be  
5           done, or what point are we at on this?

6           **DR. ZIEMER:** We have no formal motion, but  
7           the proposal from the working group included the  
8           idea that that item needs to be visited and  
9           discussed at some point in the future. As I  
10          understand it, Jim is suggesting that perhaps  
11          that should come later, perhaps as soon as  
12          tomorrow -- if I interpreted that correctly. I  
13          mean I don't want to misinterpret, but I thought  
14          I heard that.

15          In any event, I think right now we're simply  
16          discussing this as a general idea and how that  
17          fits in the framework of the task order. So --  
18          and this might be helpful to the working group as  
19          they go back and revise things for our perusal  
20          tomorrow.

21          Jim, you --

22          **DR. MELIUS:** Yeah, just let me clarify. My  
23          belief is our first priority ought to be to get  
24          this process underway and figure out how we're  
25          going to get a schedule set up, what needs to be

1 done in terms of legal procurement issues, how do  
2 we move forward as a Board to develop and approve  
3 these task orders and get them out to the --  
4 whatever contract is chosen.

5 I think as a second priority, I think we need  
6 to deal with this interview issue, and I was as  
7 much reacting to Paul's comment that maybe we  
8 should wait until we've already gone through --  
9 done some of the reviews and then decide whether  
10 we need to do -- to add interviews with the  
11 claimants to the process. And I just was  
12 remarking that I thought it should be one -- we  
13 should at least try to deal with that issue up  
14 front. But I think it's really a -- to me, it is  
15 a second priority in terms of the getting this  
16 process underway and if we can get to it  
17 tomorrow, fine. If we can't, we can't. But I  
18 think we really need to get the -- figure out the  
19 schedule and how this whole process is going to  
20 work.

21 **DR. ZIEMER:** Okay, thank you for that  
22 clarification. And I might add in terms of the  
23 interviews, as I see it, if we were to proceed in  
24 some manner, either sooner or later on that, it  
25 would have to be in the framework of spelling out

1           what the audit is going to ask for in regard to  
2           evaluating interviews.  If we have a procedure  
3           that spells out for us how we will go about  
4           evaluating the quality of the interviews, that  
5           might lead us itself to determining whether or  
6           not follow-up is needed.

7           I think I expressed before -- at least I  
8           think I did -- that we have to be very careful  
9           that we are auditing and not doing the work of  
10          NIOSH or ORAU.  If there is reason to believe  
11          that the audits are inade-- or the interviews are  
12          inadequate, and perhaps that would emerge from an  
13          audit, then in my view it's NIOSH's duty to go  
14          back and correct that issue, which might include  
15          on their part re-interviewing.  I mean I think of  
16          analogies as to how auditors -- with the  
17          exception of Andersen, perhaps -- audit books.  
18          And they make recommendations, but they don't go  
19          back and do the work of the organization.  So  
20          somewhere there's a fine line in what we will get  
21          from that, yeah.

22          Go ahead, Mark, please respond.  I'm talking  
23          off the top of my head a bit here, so --

24          **MR. GRIFFON:**  I don't want to regenerate all  
25          the discussion -- we've had discussions on this

1 before. But I think, you know, part of my notion  
2 also is that to -- if you just look at -- if you  
3 -- in the final form, you're not necessarily  
4 going to see everything that an interviewee  
5 brought up. And something that they thought was  
6 very significant, the interviewer may not have  
7 captured. And then we also in the past have  
8 raised the question of if the interviewer didn't  
9 have site-specific knowledge, they may have  
10 missed something that could have been very  
11 relevant. And so therefore re-interviewing a --  
12 and we're talking about -- from the audit  
13 standpoint, we're talking about not re-  
14 interviewing everyone. We're talking about re-  
15 interviewing a small percentage to determine if  
16 in fact the form did capture all the relevant  
17 information. And we're having -- you know, you  
18 also have to -- I mean I do understand that --  
19 you know, even though the form didn't capture  
20 every word a person said on the phone, it doesn't  
21 mean that it's not a quality final product, so  
22 we're asking the audit contractor to work with us  
23 and do a sampling of that and say okay, well,  
24 yes, it didn't capture every word they said, but  
25 it captured all the relevant information. It

1 looks like they did a fine job on, you know, 95  
2 percent of them or whatever. So that's what I  
3 was thinking.

4 **DR. ZIEMER:** Yeah. Tony.

5 **DR. ANDRADE:** Thank you. I guess perhaps a  
6 senior moment here, but I'm trying to recall  
7 whether we were really talking about a quality  
8 improvement process, which is an extremely  
9 important issue to clarify right now, and then  
10 also address the question of the types of -- that  
11 the kind of re-interview or approach to asking  
12 about an interview that has taken place -- what  
13 sort of results we expect to get and what sort of  
14 metrics we would have for success, so two things.

15 One, if we are dealing only with cases in  
16 which -- that have been closed, adjudicated and  
17 settled, then we're not going to -- we are  
18 indeed, by definition, not going to go back and  
19 open them up again or re-interview, as it were.  
20 In other words, if we find that interviews are  
21 considered inadequate in general, then that  
22 should be clearly stated up front and that will  
23 be a quality improvement process for NIOSH-OCAS  
24 to deal with. That's number one. So I need to  
25 get that clarification from Mark or somebody else

1 now.

2 Number two is if indeed we're looking at  
3 cases that have been closed, then they've either  
4 been adjudicated positively or negatively. And  
5 so I can already anticipate the result. Those  
6 that have been paid out or positively adjudicated  
7 were probably going to get -- or the staff is  
8 going to get high marks, and there may be  
9 contentious issues with those for which  
10 compensation was denied. Therefore, if you're  
11 going to start thinking process, then I think in  
12 parallel you'd better start thinking about these  
13 human issues that you're going to deal with.

14 So I'd like a response to my first one at  
15 least.

16 **DR. ZIEMER:** Thank you. Larry is prepared to  
17 respond in part.

18 **MR. ELLIOTT:** I'll respond to your first  
19 com-- question. The Board will only review and  
20 its contractor will only review adjudicated  
21 claims, those that have been -- a final decision  
22 has been proffered, they're not in appeal,  
23 they're done. You won't be looking at cases that  
24 a recommended decision's been proffered but  
25 they're not finally adjudicated. You won't be

1 looking at appeal cases. You look at those that  
2 are finally adjudicated only.

3 **DR. ZIEMER:** Right. And Gen?

4 **DR. ROESSLER:** The reason I asked if we were  
5 still discussing was I wanted to bring up pretty  
6 much what Tony has brought up. I can't picture  
7 this being an unbiased process. When it's final,  
8 if the claim has been denied, there's going to be  
9 a -- very much of a bias toward -- whether they  
10 think there's an appeal or not, toward a  
11 criticism of the process. If the award has been  
12 made, that person I think is just going to want  
13 to just say it's done; I don't have any comments.  
14 I don't know if that's -- I think that may be a  
15 bias, too. So I can't really see and I guess I'd  
16 like to be convinced of this because I can see  
17 some of the motivation for wanting to evaluate  
18 it. But I can't see much but down sides to it.

19 **DR. ZIEMER:** Jim?

20 **DR. MELIUS:** Yeah. I think as we've  
21 discussed this before, my understanding is this  
22 is not a consumer satisfaction survey that's  
23 being done, so we're not going to ask questions  
24 of, you know, was the interviewer nice to you,  
25 you know, polite and were you happy with the

1 results. It's -- I think the issue is whether  
2 obtaining additional information from the  
3 claimant would have some effect or potential  
4 effect on the case. Was there additional  
5 information that was relevant to the dose  
6 reconstruction to be obtained. And that that  
7 would have to be -- the relevancy of that  
8 information would be assessed. So yes, would  
9 there be a claimant that would say, you know,  
10 some information wasn't considered. There may be  
11 even claimants that did get compensated, may be  
12 confused about why they got compensated, so it's  
13 not an easy process necessarily to understand,  
14 particularly for people -- worked a multiple  
15 sites or multiple cancers and so forth. So --  
16 but I don't see this being done as a way of  
17 measuring consumer satisfaction. It's really is  
18 there relevant information that was -- or  
19 different information or whatever that was -- be  
20 relevant to the claim and would have changed the  
21 way the dose reconstruction would have done in  
22 either direction. It may not be necessarily to  
23 find higher doses or whatever.

24 **DR. ZIEMER:** Thank you. Tony?

25 **DR. ANDRADE:** Thank you. I don't see it as a

1 consumer satis-- if we go through with this  
2 process and it's approved and we put it into  
3 place, I don't see it ever being a consumer  
4 satisfaction interview or re-interview, either.  
5 But I just can't help but feel that the  
6 mechanisms that are in place today -- that is, a  
7 quality check and the transcript check by the  
8 interviewee of the sorts of -- well, okay, the  
9 information, the information that was tracked and  
10 that was actually written down, okay, is one  
11 pretty good indicator to the interviewee as to  
12 whether information was -- important information  
13 was captured or not. And again, I'm shifting  
14 over from just being completely factual to now  
15 the more human side of this. Somebody who's been  
16 denied is going to -- we're going to have to be  
17 extremely careful in dealing with somebody who's  
18 been denied a claim, whether the person was a  
19 petitioner or was a survivor. There are going to  
20 be strong sensitivities, strong emotions and --  
21 let's put it this way. I wouldn't be the  
22 contractor to bid on doing that kind of work.

23 **DR. ZIEMER:** Let me suggest again to the work  
24 group that they give further thought to  
25 developing the criteria for which the interviews

1 will in fact be evaluated. I think that'll be  
2 helpful to us. What are the measures that will  
3 be used to initially -- assuming you had the  
4 power to do interviews, how are you going to, as  
5 a starting point, evaluate the material that's in  
6 the file. And if you were -- had the power to  
7 interview, how would you decide which ones you  
8 would do? Is it all of them that are being  
9 reviewed or are there certain criteria that would  
10 trigger to say we -- there's something here that  
11 triggers us to think that either something was  
12 omitted or left out or what. I'm trying to get a  
13 feel for some sort of standard operating  
14 procedures by which we would evaluate to start  
15 with and then go from there. Jim, can you add --

16 **DR. MELIUS:** Well, no, I just want to clarify  
17 back to our original discussion, and I don't  
18 think this has changed. There is no transcript  
19 or recording of the interview, so that can't be  
20 referred to. All we have is the report from the  
21 interviewer. There's no routine process for  
22 going back and doing quality control on the  
23 interview process itself, as might be done, you  
24 know, in other types of studies or whatever,  
25 interview studies and so forth. So you know,

1           what we have is only from basically one person  
2           interviewing.  The only sort of quality control  
3           or whatever you want to call it is the fact that  
4           the record of the interview is sent to the  
5           interviewee for review and comment and they can  
6           send it back.  So that's the one quality controls  
7           check.  I think -- and that's the process we're  
8           being asked to look at.  Were some of these other  
9           things in place, were there transcripts of it,  
10          that might very well change how we would want to  
11          go about doing our quality control, quality  
12          assurance that we're mandated to do.

13                 **DR. ZIEMER:**  I guess what I would be -- and I  
14                 understand those points.  I guess what I would be  
15                 looking for, you know, as a starting point, the  
16                 claimant at some point agrees that -- either  
17                 agrees or disagrees that the trans-- not  
18                 transcript, the summary captures the information.  
19                 I would be -- if it were me -- looking for some  
20                 evidence that the claimant finally agreed to that  
21                 out of frustration rather than well, you know, I  
22                 can't get this claim going unless I finally sign  
23                 this thing, or something like that, as opposed to  
24                 everybody agreeing that the information has been  
25                 captured.  I mean if the claimant is agreeing

1           that the interview has captured the information,  
2           then -- then it becomes a matter of do we have  
3           other information that the claimant didn't know  
4           about in any event, which might -- which might  
5           very well be. There might have been something  
6           occur on that site, maybe it's in the site  
7           profile, that the claimant knows nothing about,  
8           and that's not a deficiency in the interview  
9           process, per se. So again, that's why I'm trying  
10          to get a feel for how we go about, as a starting  
11          point, evaluating interviews. It seems to me we  
12          can't just arbitrarily say that -- well, maybe we  
13          can -- that they are faulty because there's no  
14          transcript. I'm not willing to say that as an a  
15          priori condition if the claimant is willing to  
16          say that the content has been captured. So I  
17          would more be looking for some evidence that the  
18          claimant is sort of browbeat into that position  
19          or enters it out of frustration or some other  
20          factor. So help me out.

21                 **DR. MELIUS:** Well, I don't think that's  
22                 necessarily what we're looking for evidence of.  
23                 I think we have to remember that these claimants  
24                 are of limited education in many cases, have  
25                 limited understanding of the processes that they

1 were involved in. They were sworn to secrecy  
2 about what they were being exposed to and were  
3 given, you know, relatively little information in  
4 many cases about their exposures. To then go  
5 back, you know, 40 years later or 30 years later  
6 and then try to ask them to -- you know,  
7 interview them and have them, you know, recreate  
8 the -- what happened to them, what their  
9 exposures were is I think a very challenging  
10 process from any perspective. And I think that  
11 is what we're trying to assess. I'm not -- I  
12 think it's going to be very hard for this process  
13 to look at is there a bad interviewer. I mean  
14 our review process is just not -- you know, is  
15 there a -- were they being coerced in some way or  
16 being ignored. I mean that's a very hard -- hard  
17 to get at, but I think there really is an issue  
18 of what kind of information is being ascertained  
19 in the interview, given those circumstances and  
20 given the information available, given the time  
21 frame that's gone by and so forth. And I think  
22 we have to take a serious look at how that -- how  
23 that's being one. And I mean there are reasons  
24 why a transcript isn't being kept. I just think  
25 that limits our ability to review the process.

1 I'm not saying that that's -- should be required,  
2 but it's something that might have -- if it had  
3 been -- if it were available, then maybe we would  
4 think of other approaches.

5 **DR. ZIEMER:** Well, perhaps you've made my  
6 point for me, and that is that given then -- in  
7 many cases, the limited knowledge of the people  
8 being interviewed, that how do we in fact  
9 determine whether or not the interview is  
10 adequate? I think you're asking in a sense the  
11 same question. How do we determine adequacy,  
12 that's what I'm asking. What are our measures?  
13 So --

14 **DR. MELIUS:** I agree.

15 **DR. ZIEMER:** Yeah. Okay. Roy.

16 **DR. DEHART:** I think the point of audit is to  
17 assure that the interview has captured any  
18 corrections that is later made by the subject.  
19 In other words, the interview is given. He or  
20 she or the family says no, this is not complete  
21 and blah, blah, blah, and lists three or four  
22 additional things. Has that additional  
23 information been incorporated in the process.  
24 That we can do with the record, and I think  
25 that's appropriate to do with the record.



1 I have just one request so far. I will open the  
2 floor after that. Denise Brock is with us again  
3 from St. Louis. Denise, I drove by the arch  
4 yesterday, but I didn't stop. But we're glad to  
5 see you again and --

6 **MS. BROCK:** Thank you.

7 **DR. ZIEMER:** -- pleased to hear your  
8 comments.

9 **MS. BROCK:** Thank you. And I am here today  
10 on behalf of my mother -- again, Evelyn Cofelt --  
11 and also on behalf of all the Mallinckrodt  
12 claimants.

13 Before I forget, though, I just want to speak  
14 to what you all were discussing. What I did  
15 during my mother's telephone interview was just  
16 got a voice-activated recorder and I used a  
17 speaker phone, and that's what we used actually  
18 after we got our draft or hard copy back to go  
19 back over, and we had our notes in front of us,  
20 and I'm sure not everybody is quite that extreme  
21 when they do things, that's just my personality.  
22 But that's what we did and we sort of went over  
23 that process to make sure that everything that  
24 was asked was touched upon and -- and it was  
25 basically a summary, and we had a few kinks in it

1 that were eventually corrected.

2 But I agree with Dr. Melius. These workers  
3 had no idea what they were exposed to in most  
4 cases. I mean there were code names. I think I  
5 mentioned that before -- tube alloy, biscuit --  
6 they didn't know about transuranics and things  
7 like that. So I really don't know what sort of  
8 questions to -- that you would even ask in a  
9 situation like that. I mean I'm kind of on the  
10 other end of it.

11 I do have a letter from one of -- I call them  
12 my claimants -- and this is a female. She didn't  
13 want her name mentioned, but at the end of it --  
14 and I don't know how pertinent this is, but she  
15 says (Reading) I worked nine years for a company  
16 that I had no idea what was being done there.  
17 Yes, I knew it had to do with uranium, but I  
18 don't think any one of us had any clue as to the  
19 dangers of this uranium or the presence of other  
20 chemicals and what it could do to our bodies. I  
21 had no reason not to trust Mallinckrodt or the  
22 Atomic Energy Commission. When I first read  
23 about the compensation and why it was being  
24 given, I felt anger and disappointment that our  
25 government had put us in harm's way without our

1 knowledge or consent. Thank you for listening to  
2 my statement.

3 And that's just part two of her letter. But  
4 I think that that seems to be not an anomaly. I  
5 don't think these people knew what they were  
6 exposed to. And then years later we have all  
7 these sick or deceased individuals.

8 And as far as the process itself, would there  
9 not be a way perhaps for NIOSH or ORAU or whoever  
10 is conducting the interview itself to somehow  
11 record that? I mean -- because I mean we could  
12 try to tell all the claimants to try to get a  
13 speaker phone and a voice-activated recorder, but  
14 I think it would be much easier for somehow the  
15 Federal officials to -- to record these. Is that  
16 a possibility?

17 **DR. ZIEMER:** Thank you, Denise. I think  
18 we've addressed that before and perhaps one of  
19 the Federal officials will address it again. Did  
20 you have additional comments that --

21 **MS. BROCK:** Oh, yes, I do.

22 **DR. ZIEMER:** Okay, please -- please proceed  
23 and then we'll --

24 **MS. BROCK:** And that's another thing I wanted  
25 to say is that this is probably going to be quite

1 lengthy, so if at any time you need to cut me  
2 off, that's fine. I'll be here tomorrow, too.

3 Today I have some comments I'd like to make  
4 that are rather personal, and I also have some  
5 questions that I'd like to raise with the Board.  
6 I don't know if anybody prefers which I do first  
7 -- okay, then I'll just start. Again, the  
8 comments I have to make at this beginning part  
9 are personal. The remaining amount will be as to  
10 the Mallinckrodt claimants.

11 August 15th, Friday, was my father's  
12 birthday. My father's been dead since 1978, so  
13 obviously we've went through many birthdays  
14 without him. But this year seemed to be a little  
15 bit different, and I think that's for numerous  
16 reasons. Probably one because of this whole  
17 process that I've been doing for a little while  
18 now.

19 But secondly, there's been a lot of publicity  
20 in the state of Missouri with what I'm doing.  
21 Poor Larry I think has gotten part of that  
22 because I know that they call him, the reporters  
23 and senators and so on and so forth. But in the  
24 process of that, I have met some very wonderful  
25 people and one woman reporter has just been

1           amazing. Her name's Gerri Dryling\*. She did a  
2           *Riverfront Times* article in St. Louis, very  
3           lengthy article. She's very empathetic, just a  
4           wonderful person.

5                     And in doing that, there's a lot of questions  
6           that are asked that brings up a lot of memories.  
7           In one way it's therapeutic, but in another way  
8           it -- it brings up a lot of things that maybe you  
9           wouldn't really want to remember. And that's  
10          when I'm going back to my father's birthday or  
11          Christmases that we spent. And I'd just like to  
12          say that as a child I grew up knowing my father  
13          had cancer. I believe I was probably five or six  
14          when he was diagnosed with lung cancer, and I  
15          grew up knowing that word.

16                    I grew up knowing the word "terminal", and  
17          probably never really, unfortunately, thought  
18          much about that. I guess you would say  
19          unfortunately. My parents had a very good knack  
20          of protecting us. I didn't even know we were  
21          poor, but I guess we were. We lost our home due  
22          to the financial problems. I mean it ravaged our  
23          family. We lost our home, our car, our  
24          furniture. And we lived in a really nice house,  
25          but I was kind of a goofy kid and thought that

1 moving to something with wheels on it would be  
2 just really an adventure, and that's what we did.

3 And I never knew that until recently when I  
4 talked with my brother that on Christmases -- my  
5 father had seven sisters -- and he would do  
6 whatever had to, he and my mother of course, to  
7 make sure that we had everything we wanted for  
8 Christmas. Christmases and birthdays were pretty  
9 weird, though, because the biggest part of those,  
10 from what I can remember, were spent in a  
11 hospital. It was called Barnes Jewish and there  
12 was a special area called Queenie Towers is what  
13 I remember mostly. And I can remember being  
14 pretty young and sitting on the floor playing  
15 with Barbie dolls on Christmas day. And there  
16 would be a tree in his room and sometimes a  
17 priest giving him last rites or his sisters being  
18 around him.

19 I can even remember leaving the room at one  
20 time for whatever reason I had to leave, and I  
21 had a -- this is silly. I had a purse that had  
22 this long fringe on it, I just loved it, and my  
23 dad was in the hospital and he -- I knew he  
24 bought these things. They were called Little  
25 Kiddle dolls. They were these little bitty dolls

1 with like a bubble over them. And when I left  
2 the room I had went to the downstairs part of the  
3 hospital by myself and was actually robbed.  
4 Somebody stole my purse. I think I was probably  
5 about seven or eight.

6 Those are the kind of memories I have, along  
7 with remembering that when I was old enough  
8 sometimes my brother and I would be home alone  
9 with my father. And back then they had those  
10 real big oxygen tanks where you had to adjust the  
11 knob to get the right flow of oxygen. He had  
12 Tupperware containers full of medication. I know  
13 it sounds silly now, but when we were little I  
14 would be afraid that maybe I turned it up too  
15 high to too low or gave him the wrong medicine at  
16 the wrong time.

17 Sometimes I remember being afraid -- sorry --  
18 thinking that if he slept too soundly maybe he'd  
19 be dead, and I wouldn't want to go in the room.  
20 But I had a younger brother, so I would make a  
21 lot of noise. I didn't care if I got in trouble.  
22 I just wanted to -- to hear him. And I would go  
23 in and I would shake him really hard, just to  
24 hear him, you know.

25 And that brought me to the day he died, which

1 is really significant because I don't know if it  
2 was out of habit or just being a smart ass, but I  
3 can remember standing at my door waiting for the  
4 bus. And I hollered to him and he didn't answer.  
5 So I thought well, I don't care, I'm going back  
6 to his room. I don't care if I miss the bus. I  
7 went back and I shook him really hard and I said  
8 goodbye, I love you. And he looked at me right  
9 in the eye and said I love you, too. And about  
10 five hours and ten minutes later, my brother came  
11 to school -- I was a senior in high school -- and  
12 he walked into my classroom and told me that my  
13 father sat up and clutched his chest and died in  
14 his arms.

15 We buried him a couple of days later in a  
16 cemetery across the street with a real small  
17 headstone. You know, again, I was real young and  
18 didn't pay attention to not having anything until  
19 maybe -- maybe six months or a year later, phone  
20 calls started coming in. Bill collectors, my mom  
21 even got served with some sort of subpoena to go  
22 to court. They were going to try to get a  
23 judgment against her over a headstone.

24 And now that I think of this stuff and I  
25 think about I'm groveling for her for \$150,000

1 from a vendor that poisoned -- and a government  
2 that poisoned my father, gave him cancer, it ate  
3 and ravaged his body, it just -- to me it's  
4 obscene. It's just absolutely obscene and I have  
5 no hard feelings against anyone in this room, but  
6 I just think it's appalling. This is not an  
7 anomaly.

8 My story -- I didn't tell this for anybody to  
9 feel sorry for me. I hear stories like this  
10 every day. And I think it's one of the saddest  
11 things there is. These people protected their  
12 government and died because of that, and now they  
13 or their survivors are having to jump through  
14 hoops and come up with details of stuff that has  
15 been long since destroyed. And again, if this  
16 was for me, they could stick it. But this is for  
17 my mom who's 80 years old, who lives on under  
18 \$1,000 a month that can't even afford her  
19 medication. And I'm hoping that she gets a check  
20 so she can at least live long enough to see that  
21 and maybe kind of have some of the burden lifted  
22 off of her, as well as the other claimants.  
23 Thanks.

24 And do I have time to ask questions now? Do  
25 I? To Larry, is there any idea of the time frame

1 of when the rule may be finalized in order to  
2 petition for Special Exposure Cohort?

3 **MR. ELLIOTT:** The rule you're referring to is  
4 the rule on adding classes to the Special  
5 Exposure --

6 **MS. BROCK:** Yes.

7 **MR. ELLIOTT:** -- Cohort? And we have been  
8 addressing the public comments received under  
9 public comment period, redrafting the rule in  
10 accordance in how we have addressed those  
11 comments. We're hopeful that by the end of the  
12 year we will see a new rule issued.

13 **MS. BROCK:** Okay, thanks. Also, in a letter  
14 to one of my claimants -- I think Dr. Toohey and  
15 I touched on this -- from Dr. Toohey, it was  
16 dated July 15th, 2003. It stated -- I understand  
17 that it is expected to have completed dose  
18 reconstructions for most of the Mallinckrodt  
19 claimants by this fall.

20 And also I'd read an e-mail that says by  
21 September. Would that -- is that close to  
22 accurate? I mean do you expect to have most of  
23 these dose reconstructions done by fall or  
24 September?

25 **DR. ZIEMER:** Yeah, I guess we'll probably get

1 a detailed report tomorrow on that, but is there  
2 a brief answer, Jim?

3 **DR. NETON:** Yeah, that's right, tomorrow  
4 we're going to talk about the performance plan in  
5 a little more detail, and particularly the  
6 technical basis documents I'll be addressing  
7 tomorrow. But we're very close on the  
8 Mallinckrodt technical basis document. I think  
9 latest indications are maybe within a week or two  
10 the first draft will be available. And once it  
11 gets approved by us -- I mean NIOSH has to review  
12 it and bless it. Once that's done, then it -- it  
13 takes a little while to get the technical basis  
14 document implemented. It's not like you can  
15 write the document and then tomorrow start  
16 generating the dose reconstructions. There's  
17 about a month in between there where it needs to  
18 be -- the process needs to be worked out a little  
19 better.

20 **MS. BROCK:** By technical base (sic) document,  
21 is that the site profile? I'm sorry, is that  
22 what that is?

23 **UNIDENTIFIED:** (Inaudible)

24 **MS. BROCK:** Okay. And that was my next  
25 question, is was it finished. With your site

1 profile -- I'm curious because I'm just not real  
2 familiar with that -- do you also, when you --  
3 when you do those, do you base it on the  
4 epidemiological studies that were also done on  
5 those facilities?

6 **DR. NETON:** No, the site profile is an  
7 exposure model. It has nothing to do with the  
8 epidemiologic evidence. It has to do with the  
9 facts surrounding the source term of the  
10 materials that were there, the air sample data,  
11 the bioassay data, those type of parameters are  
12 included in the document. But the epidemiologic  
13 evidence is not included in there. The  
14 probability of causation model of course is the  
15 model that does the -- that uses the  
16 epidemiology. And as we've discussed at past  
17 meetings, currently there are no DOE worker  
18 epidemiologic studies that are used in the  
19 probability of causation model at this time.

20 **MS. BROCK:** I guess that kind of confused me  
21 a little bit. I've got something that I thought  
22 was interesting and I just wanted to comment. It  
23 says (Reading) In order to estimate exposure, it  
24 is essential to know the amount of a pollutant  
25 released to a particular medium such as air or

1 water from a source pollution, called a source  
2 term, or to have an accurate history of  
3 concentrations of pollutants in air, water and  
4 soil.

5 So I'm curious, with Mallinckrodt, because  
6 there is such a loss of records -- and I  
7 understand you state that you have quite a bit on  
8 site profile -- but what about situations -- and  
9 again, I probably have asked this before -- where  
10 you have like the daughter products? I mean like  
11 if you have naturally occurring Pu-244 from this  
12 Belgian Congo pitchblende and if you have  
13 actinium and polonium and the radon, can you --  
14 is that -- is there enough there to get an idea  
15 about where this was and how much these people  
16 were exposed to if there's not individual data?  
17 And if there was not any internal or a lot of  
18 internal, there was just breath -- some breath  
19 radon and mostly external, is there enough to do  
20 that on?

21 **DR. NETON:** I think it'll be more evident  
22 when the model comes out and -- or the technical  
23 basis document or the profile, and it'll be on  
24 our web site, by the way, for anyone to evaluate.  
25 But the short answer is we try, whenever we know

1 that there are materials that weren't monitored  
2 that were included in the exposures, we'll add  
3 them in to the claimant's dose. And that would  
4 be reflected in the site profile itself.

5 As most things go with this program, if we  
6 don't know and we have to make a judgment call,  
7 then we will err on the side of being favorable  
8 to the claimant.

9 **MS. BROCK:** Thank you. And to the epi  
10 studies, I wanted to ask a question about  
11 Elizabeth DuPre Ellis\*. I understand that she  
12 had published some studies quite some time ago,  
13 the mortality studies. It's my understanding she  
14 completely excluded internal dose. Is that what  
15 you would be looking at, because she also has  
16 some non-published -- for some reason, some non-  
17 published documents and I was kind of curious why  
18 that was non-published. And I also have  
19 something -- let me look through my paperwork,  
20 but I believe I have something -- there was like  
21 20.8 percent that actually was missing on the  
22 published. Which do you use, do you use the  
23 published, the non-published?

24 **DR. NETON:** Again, back to one of the earlier  
25 questions, we would not use the epidemiologic

1 study to do the dose reconstruction at all. I  
2 mean those are independent datasets. And it's  
3 true and many times internal dose is difficult to  
4 decipher and many epidemiologic studies in the  
5 DOE work force have tended to not evaluate the  
6 internal dose completely. But we would not be  
7 using either of those epi studies to do the dose  
8 reconstructions themselves.

9 **MS. BROCK:** And I think I just kind of wanted  
10 to comment, because I know my concern is also the  
11 concern of many of the claimants, probably  
12 because we are not scientists or health  
13 physicists, but it is very difficult to  
14 understand. But I just wanted to read something.  
15 (Reading) The Department of Energy occupational  
16 epidemiologic studies constitute one of the  
17 world's largest and most extensive follow-ups of  
18 people exposed to low level ionizing radiation  
19 and other substances. The studies were initiated  
20 36 years ago and cover some 600,000 people who  
21 worked for Federal contractors at industrial and  
22 research sites. These workers helped produce  
23 tens of thousands of nuclear weapons for the  
24 United States. Many were followed for more than  
25 50 years when the first nuclear weapons were made

1 during World War II. From the very beginning it  
2 was recognized that the risks posed to nuclear  
3 weapons workers over time were not well  
4 understood. Dr. Robert Stone, the head of the  
5 health division of the Manhattan Project, noted  
6 that worker radiation protection rested on rather  
7 poor experimental evidence. He concluded the  
8 whole clinical study of the personnel is one vast  
9 experiment. Never before has so large a  
10 collection of individuals been exposed to so much  
11 irradiation.

12 And I think sometimes that that's kind of  
13 scary for some of us because we're not really  
14 sure how accurate the site profiles are and how  
15 accurate the epi studies are. And I guess I was  
16 rather confused because I -- I know there were --  
17 Merrill Eisenbud\* had talked about Harshaw\* and  
18 Mallinckrodt being the two worst I believe in AEC  
19 history. And I understand in one of his  
20 biographies he had stated quite a few things to  
21 Ms. Dupre Ellis and a lot of that wasn't even  
22 commented on in some of her studies, so I think I  
23 was a little bit concerned, but I feel better  
24 now.

25 And I also wanted to make comment, and I

1 don't know -- with the Department of Energy, I  
2 think somebody had touched on it earlier about  
3 waiting for exposure data to come back to the  
4 Department of Labor. I've had a personal  
5 experience with the Department of Energy. I  
6 think I had spoke to that once before about I had  
7 filed a FOIA request, actually several, one on  
8 behalf of my father and one on behalf of all of  
9 Mallinckrodt -- not had much response at all.  
10 But what I did get on behalf of my father, as I  
11 stated previously, was from the Department of  
12 Energy a document stating that he was under Q  
13 clearance, had the issuance date, the termination  
14 date, with a letter stating all other files had  
15 been destroyed.

16 A couple of months later, actually June 13th,  
17 I receive a letter from the Department of Labor  
18 stating DOE has verified his employment. And  
19 they had some records -- actually things that I  
20 had never gotten and they told me they never had,  
21 showed him as a powerhouse operator. They were  
22 actually equating the dates of employment with  
23 the issuance and termination dates of Q  
24 clearance. They -- it was just kind of peculiar  
25 to me.

1           When I asked them about it, they denied it,  
2           said it didn't come from them. Well, I have  
3           those files and it did come from them. And so my  
4           concern here is that if we're waiting for the  
5           Department of Energy to come up with records that  
6           we can't get -- and I know nobody can comment on  
7           this -- but my concern is are they incompetent,  
8           are they lying, and is this what we're waiting  
9           for for people to base dose reconstruction on?  
10          It's very, very disconcerting.

11          Also I notice that the Department of Energy  
12          -- we have something called SLAP, St. Louis  
13          Airport storage site, and they had removed the  
14          DOE designation off of there -- really nice man,  
15          Roger Anders, I called him. I called him  
16          repeatedly. And I asked him about that and he  
17          said well, he didn't think that DOE had done any  
18          cleanup there. And I asked him to give me about  
19          ten minutes and I would send him the documents to  
20          show that they had. I know they did at least two  
21          rounds. And I've done that and they are making a  
22          formal change.

23          But that also scares me, too, because what  
24          that does is leave my subcontractors out there  
25          who possibly were involved in cleanup without any

1 remedy.

2 They also said there was no beryllium there.  
3 I've got beryllium added and I'm getting ready to  
4 add it to two other sites, as well, because I've  
5 got the documents to prove that. So all of this  
6 is kind of scary because you've got lay people  
7 such as myself -- and this is not my forte -- and  
8 I'm having to dig this stuff up to help people.

9 And talking about reports, the *Labor Tribune*,  
10 which is a paper that our unions have for the  
11 building and construction trades, did a story and  
12 it went out to 90,000 people. So they  
13 accidentally put the wrong number in for Paducah  
14 so all the claims are coming to my house, so I  
15 forward those on. That's all right. My daughter  
16 kind of goes insane with it, but I think that  
17 that's going to generate numerous claims, as  
18 well.

19 And I don't know if anybody knows, but is it  
20 true that the Department of Energy can come in  
21 and screen these subcontractors? I've got guys  
22 that need to be tested for CBD and for cancer.  
23 Do they have some sort of -- I thought they did  
24 that in other areas. Can I have them -- somehow  
25 get them to come in and test these workers? Are

1           there mobile units or does anybody even know  
2           that?

3           **UNIDENTIFIED:** You need to talk to DOE.

4           **MS. BROCK:** DOE, yeah. And why is it that  
5           DOE is never here? There's never a  
6           representative. Is that because this has nothing  
7           to do with DOE, because I see the things on the -  
8           - no? I really think we should invite them.

9           And the last thing I think I wanted to say  
10          today --

11          **DR. ZIEMER:** Incidentally, we have not closed  
12          this meeting to DOE, so...

13          **MS. BROCK:** And the last thing I wanted to  
14          ask today was to please come to St. Louis because  
15          I betcha I could fill up a room with at least 400  
16          people for you. Thank you.

17          **DR. ZIEMER:** Okay. Thank you, Denise, for  
18          your comments.

19          Okay, we have a request from Richard Miller  
20          from GAP. Richard, please address us.

21          **MR. MILLER:** Dr. Ziemer, thank you. Good  
22          afternoon. My name is Richard Miller. I'm from  
23          the Government Accountability Project. I had a  
24          couple of brief questions and points. The first  
25          is, in reviewing the site profiles I've noticed

1 that apparently there's a NIOSH version of IMBA,  
2 and I wondered whether this could be made  
3 available to the public on NIOSH's web site, the  
4 way that IREP is available, so that we can take  
5 the dose information that is presented and uptake  
6 and convert it into individual organ dose. That  
7 makes it somewhat difficult to have to find  
8 people with IMBA and waste their time running the  
9 numbers. And it does seem that if you've  
10 purchased such a model, it would be very helpful  
11 to the public to have it available so that the  
12 site profiles can be converted into something  
13 useable for the lay person.

14 **DR. NETON:** IMBA currently, as it exists, is  
15 a stand-alone program that runs on a PC. I'm not  
16 sure that anything precludes it from running as a  
17 web-based software, but we would have to check  
18 into our licensing agreement with the vendor  
19 before we'd even be able to entertain that  
20 possibility.

21 **MR. MILLER:** Well, at this point then you  
22 will have the monopoly on converting the data if  
23 it's not made available, so I appreciate you have  
24 a licensing issue, but I -- and certainly if you  
25 want to -- if you want to have people write in

1 for a CD, we're happy to do that. But you know,  
2 as a -- a task order contract?

3 **DR. NETON:** (Inaudible) task order contract  
4 will have access to IMBA.

5 **MR. MILLER:** Well, that's great, but what  
6 about the rest of us? I mean we've got access to  
7 IREP. Now unless -- unless -- do we need more  
8 than one program? Do we need more than IMBA to  
9 be able to convert it? Because I also noticed  
10 that there was a second program that was  
11 mentioned in the Savannah River, I believe, site  
12 profile -- forgive me, I don't have the document  
13 with me, but there -- I mean if there's --  
14 whatever program you need to convert dose, you  
15 know, that information, whatever -- whatever  
16 combination or individuals are, I think it would  
17 be immensely valuable. And I think -- otherwise  
18 this program's going to lose transparency.  
19 Right?

20 **DR. NETON:** We can explore that possibility  
21 and see what can be done to make that available.

22 **MR. MILLER:** Okay, that'd be great. Thank  
23 you.

24 The second question has to do with the --  
25 sort of the shift in the program and the audit.

1 I remember sitting -- it must be a year ago --  
2 through meetings about the development of the RFP  
3 for the audit and what would go into the scope.  
4 And what's happened to the program -- at least  
5 this is my observation, and maybe it's a  
6 mischaracterization, but site profiles were going  
7 to be these things out there and there were going  
8 to be these worker profiles, and the RFP that  
9 went out said you were going to do five sort of  
10 worker profile/site profiles I think per year,  
11 and then you'll do so many in depth and so many,  
12 you know, standard dose reconstructions and so  
13 many blind and so forth. But what it looks like  
14 now is that as you've gotten more experienced  
15 with the program and you've tried to find ways to  
16 get some efficiencies, you're doing a lot --  
17 looks like a lot more site profiles than was  
18 discussed a year ago when the RFP was in its  
19 development stages. And it seems to me at this  
20 point -- this is my observation -- that given the  
21 high degree of reliance upon the site profiles to  
22 inform the dose reconstructions -- and I'm only  
23 basing this on having watched what happened with  
24 the exposure assessment, at least at Bethlehem  
25 since that seems to be the lion's share of the

1 cases that have cranked through and I have the  
2 great pleasure of receiving the phone calls from  
3 people who were denied mostly so I get a little  
4 bit of insight into some of these cases.

5           Would it make sense for the Advisory Board --  
6 and it may even be an efficiency method for you  
7 all, as well -- to think about auditing all of  
8 the site profiles, 'cause there's a discrete  
9 fixed population of them, many of which it  
10 appears are going to serve as a cookie cutter for  
11 "me, too" sites, so your uranium rolling mills,  
12 you'll use the basic same method, you know, as  
13 tailored. Or the same uranium extraction process  
14 where you have phosphate fertilizer plants that  
15 also extract uranium and so you'll have a sort of  
16 a cookie cutter there, and you can sort of see  
17 how this program's shaping around types of  
18 production where there's common -- particularly  
19 in the AWEs -- some commonality and probably in  
20 some of the production sites, the DOE productions  
21 sites, to audit all of them. In other words, to  
22 think about whether it makes sense.

23           Now I don't know whether this implicates your  
24 RFP or not and your procurement process and its  
25 integrity and whether people will come in

1 complaining after the fact that, you know, they  
2 bid on one thing and awarded a contract for  
3 another. But you know, I just would sort of  
4 float that as a thought, that -- that -- I'm not  
5 sure if five site profile reviews are going to be  
6 sufficient in the first year if the productivity  
7 of these site profiles starts pouring out and  
8 they are then the foundation for knocking out  
9 scores of dose reconstructions thereafter based  
10 on that model. So I would just offer that as a  
11 suggestion. You might even be able to audit  
12 fewer dose reconstructions but do more site  
13 profiles. It just seems that way.

14 The next -- the next question was -- and  
15 maybe this can be addressed tomorrow, but I  
16 noticed in the handouts that there was a vast  
17 increase in staffing in this program from the  
18 last time we saw it in terms of contractor, ORAU  
19 staffing. It looked like it was over 250 staff  
20 at this point, contractor staff. And it would be  
21 very helpful -- if not tomorrow or at some point  
22 -- for there to be some discussion about who are  
23 these people, where are they, where did they come  
24 from. That's a big pump -- are these people  
25 employed by DOE contractors today and they're

1 working as consultants to the program? Are these  
2 people who are, you know, retired and they --  
3 consultants? Are they competitors that were  
4 disappointed? I mean where did they come from to  
5 get such a huge boost in staffing, and are all  
6 these people sort of cognizant of kind of the  
7 approach to the program and -- and -- and vetted  
8 for conflict of interest?

9 And then the last comment I guess I would  
10 offer sort of spoke to Subtitle D. DOE abolished  
11 its advisory committee. The Secretary apparently  
12 saw fit to eliminate it on January 1st, so what  
13 was known as WAACee\*, or the Worker Advocacy  
14 Advisory Committee, is no more. Which was too  
15 bad 'cause it was a pretty distinguished group of  
16 individuals.

17 The problem arises that your program  
18 interfaces with that in a very important way, and  
19 that is this. There are many radi-- there are  
20 many dual filings of claims. I mean people filed  
21 under D and B simultaneously, and a number of  
22 those are for cancer cases. And what's happening  
23 is that the physicians panel are being given  
24 cancer cases to evaluate without dose  
25 reconstruction or probability of causation

1 findings. Now DOE has a different standard of  
2 causation than this program. This is an as-  
3 likely-as-not standard for Subtitle B. Subtitle  
4 D is the -- well, by the time they worked out the  
5 rule, it was sort of a significant factor which  
6 aggravated, caused or contributed to the illness  
7 or death. So you have a lower standard of  
8 causation under the -- or lower threshold for  
9 establishing causation under the DOE program.

10 Nevertheless, DOE is now sending to  
11 physicians claims without the benefit of your  
12 work. And it seems to me -- although this is not  
13 DOE I'm speaking to and obviously they didn't see  
14 fit to come to very many of your meetings, and I  
15 don't mind that being put on the record; it sort  
16 of shows some kind of indifference which is not  
17 lost on the public -- that the dilemma is they're  
18 going to now deny claims because there's an  
19 absence of information which you all are going to  
20 be developing at some point which is either going  
21 to be lost or have to be re-adjudicated again  
22 with the benefit of your new information. And I  
23 don't know whether it's appropriate or not for  
24 this body to take up that question, but I think,  
25 given that there's 18,000 claims at DOE and there

1 are at least 4,000 claims that have nothing to do  
2 with any radiation-related cancers -- asbestosis,  
3 you know, chronic obstructive pulmonary disease  
4 from, you know, caustics or whatever -- that it  
5 might be appropriate to take that up and wait for  
6 y'all's work product before they -- you know,  
7 kind of triage matters, I guess that's the nice  
8 way of putting it. Because there is a lot of  
9 valuable work and investment going into this that  
10 will not -- whose fruit will not be enjoyed by  
11 another program.

12 Now I know you don't advise Secretary Abraham  
13 nor profess to, but if there's some way to  
14 facilitate communication -- I mean really I  
15 think, at the risk of being inappropriate here, I  
16 believe you're somehow tied to the physicians  
17 panels in some respect and maybe --

18 **UNIDENTIFIED:** (Inaudible)

19 **MR. MILLER:** Yes, I think -- I mean I don't  
20 know whether it's possible to give some insight  
21 to your colleagues here, but I think it's a huge  
22 waste not to take advantage of your work at DOE.  
23 We don't have an advisory committee to talk to  
24 there anymore, so you're it. Those are my  
25 thoughts.

1           **DR. ZIEMER:** Thank you, Richard. Any  
2 comment?

3           **MR. ELLIOTT:** Richard, I appreciate your  
4 comments. You're certainly very correct that we,  
5 too, would like to see DOE hold the cancer-  
6 related claims until our dose reconstructions are  
7 finished. And in our coordination with other  
8 agencies, we've talked about this. But for this  
9 Board's perspective, this is not within your  
10 charter. It's not something the Secretary is  
11 asking you to do. Richard, your comments are on  
12 the record and that's where they can stand and be  
13 heard. I think that's enough said.

14           **MR. MILLER:** Great, well, we'll -- I mean  
15 that's great. I -- I know, it's a hard problem.  
16 We used to talk about pushing on a string --  
17 right? -- when you couldn't lower interest rates  
18 any further and you still can't push people  
19 along. Sometimes I feel like that's where we  
20 are. But -- and I will look forward to your  
21 response with respect to the IMBA question at --  
22 and see what you can get for us. Thank you.

23           **DR. ZIEMER:** Okay. Thank you very much.  
24 We're coming to the close of today's session.  
25 Let me ask if there's any housekeeping items we

1 need to address today, Cori, or other staff?

2 **MS. HOMER:** Just remove your laptops and  
3 bags.

4 **DR. ZIEMER:** Don't leave things in this room  
5 tonight. Right? Thank you very much.

6 **MR. GRIFFON:** One thing, Paul.

7 **DR. ZIEMER:** Right.

8 **MR. GRIFFON:** Just a question. The working  
9 group is going to meet in here at 7:00 --  
10 assuming that the door will be open, in here at  
11 7:30 tomorrow morning, and I would ask maybe if  
12 Jim Neton -- I didn't ask Jim before -- if you  
13 can meet with our working group tomorrow morning?

14 **DR. NETON:** What time?

15 **MR. GRIFFON:** 7:30, and possibly somebody to  
16 help with the procurement questions, too, legal -  
17 - if someone from legal is available --

18 **DR. ZIEMER:** Okay, and then --

19 **MR. GRIFFON:** -- for our breakfast meeting.

20 **DR. ZIEMER:** Right here?

21 **MR. GRIFFON:** Yeah.

22 **DR. ZIEMER:** And then --

23 **UNIDENTIFIED:** Is it going to be open?

24 **MS. HOMER:** I'll make sure.

25 **DR. ZIEMER:** Yeah. Our open time -- or our

1 meeting begins at 8:00, which is the -- the  
2 normal registration period, with the formal  
3 meeting beginning at 8:30.

4 **MR. ELLIOTT:** We have that agenda change.

5 **DR. ZIEMER:** The agenda change is we will be  
6 moving up -- the agenda item that appears as  
7 scientific issues work group report, that report  
8 is -- will be deferred or at least will not occur  
9 tomorrow. I don't know if John Till is prepared  
10 to start early, but --

11 **MR. ELLIOTT:** Probably not. You'd better let  
12 him start when he was scheduled to start.

13 **DR. ZIEMER:** Right. So unless John Till  
14 wants to start early, and we don't know  
15 necessarily that he would even be here at that  
16 hour -- well, in any event, we may have to start  
17 at 9:00 then, unless there's something we can --  
18 I'm wondering if -- I wonder if -- or perhaps we  
19 can move one of these other ones up on this  
20 agenda, but I'll work that out separately, so  
21 let's plan to begin at 8:30 and we'll just shift  
22 things around a little bit.

23 So we are recessed till tomorrow morning.

24 (Whereupon, an adjournment was taken to  
25 August 19, 2003, at 8:30 a.m.)

1

