

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

NINETEENTH MEETING

ADVISORY BOARD ON
RADIATION AND WORKER HEALTH

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at The Westin Casuarina, 160 East Flamingo Road, Las Vegas, Nevada, on December 9 and 10, 2003.

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TRANSCRIPT LEGEND

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(in order of appearance)

Ms. Chris Ellison, NIOSH

Mr. Jeff Kotsch, DOL

Mr. Stu Hinnefeld, NIOSH

Mr. David Allen, NIOSH

Dr. James Melius, Workgroup Chair

Dr. John Mauro, SC&A

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RICHARD MILLER
DAVID NAIMON

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KNUTE RINGIN
CHUCK ROESSLER
BRIAN THOMAS
RICHARD TOOHEY

1 P R O C E E D I N G S

2 **Error!**

3 (8:30 a.m.)

4 **REGISTRATION AND WELCOME**

5 **DR. ZIEMER:** Good morning. I'd like to call to order the
6 19th meeting of the Advisory Board on Radiation and
7 Worker Health. I'm Paul Ziemer, Chairman of the Board,
8 and the other members of the Board are all present and
9 you see their names on the placards before them.
10 This is a slightly different venue than we're used to. If
11 we do well today, I understand that we may become
12 permanent replacements for Siegfried and Roy, but we'll
13 see how it goes. If you're here expecting to hear
14 David Brenner, you're here too early today. Besides,
15 he charges \$50 a person and this show is free. And
16 they say you get what you pay for.
17 I'd like to welcome not only staff from several Federal
18 agencies, but other members of the public who may be
19 here this morning. We'd like to remind all of you --

1 Board members, Federal staff, contractor staff and
2 members of the public -- to please register your
3 attendance in the book that's out at the entrance.
4 Also members of the public, if you wish to make public
5 comment during one of the public comment periods, the
6 first of which will be about mid-afternoon -- 2:45 --
7 to please sign up at that registration book so that we
8 have some idea of how many will be presenting at that
9 time.

10 There are copies of a number of items on the table over here
11 on my left near the rear. Some are presentations that
12 will occur today. There's copies of the agenda. There
13 are copies of past Board minutes and other related
14 items, so please avail yourself of that information, as
15 well.

16 Finally, we do welcome you to Las Vegas. This seems like an
17 appropriate place to talk about probabilities and
18 risks, although I'm sure the view here gets distorted
19 because people seem to think they can beat the
20 probabilities. In any event, let me turn the mike over
21 briefly to Larry Elliott to add a few comments.

22 **MR. ELLIOTT:** On behalf of the Director of NIOSH, John

1 Howard, and the Secretary of Health and Human Services,
2 Secretary Thompson, I'd like to welcome the Board to
3 Las Vegas. I'd like to welcome the public to this
4 meeting. It is a public meeting.

5 We would like to apologize for the particular forum that we
6 are presented in here today. We typically use a
7 different forum, a more level playing field, if you
8 will, where the Board is on the same level with the
9 audience. Unfortunately, in this hotel, the room that
10 we had contracted was not available for us. It's not
11 got a building inspection permit and there's an egress
12 problem, so this was the only other space that was
13 available to us. And because we have announced this
14 public meeting in the *Federal Register*, we must hold it
15 here at this address. And so we'll make do here today;
16 I beg all your indulgences.

17 We have a busy agenda, and I look forward to a productive
18 meeting. Thank you.

19 **DR. ZIEMER:** Thank you, Larry. The minutes for meeting 18,
20 which was the meeting held in St. Louis, Missouri in
21 October, were provided to the Board in their books,
22 which many of them only got this morning. And the

1 minutes are fairly lengthy, so without objection, I'm
2 going to defer action on the minutes until our meeting
3 tomorrow.

4 **MS. MUNN:** Thank you.

5 **DR. ZIEMER:** I do ask the Board members in the meantime to
6 spend their evening in their rooms reading the Board
7 minutes. But more seriously and particularly, look at
8 those areas in the minutes which summarize discussions
9 that you might have contributed to to make sure that we
10 have accurately rendered your thoughts. For example,
11 I'm going to ask Dr. Roessler to check her thoughts --
12 the rendering of her thoughts because I can't figure
13 them out in the minutes --

14 **DR. ROESSLER:** I'll see if I can.

15 **DR. ZIEMER:** -- and I'm hopeful that she can, and there may
16 be others like that, as well. I'm not picking on her,
17 but I don't think the minutes maybe fully reflected
18 what was being said. But particularly check those
19 areas where there is sort of a summary of what your
20 views or thoughts were on particular issues.

21 And if you have other changes that you would like to make,
22 we'd like to have those by tomorrow. And Ray, our

1 court recorder who also prepares the summary minutes
2 for us, will be able to incorporate those changes
3 before we issue the final copy. So be prepared
4 tomorrow to identify any substantive changes and then
5 we'll also get from you -- and you can turn them in on
6 your own -- any grammatical changes that you might
7 note.

8 Are there any questions on those minutes other than the
9 remarks I've just made?

10 (No responses)

11 **DR. ZIEMER:** Okay, thank you very much. Then we will defer
12 action on those until tomorrow.

13 **PROGRAM STATUS REPORT**

14 We'd like to proceed then with the next item on the agenda,
15 which is the program status report. Chris Ellison's
16 going to present that for us today. I should point
17 out, particularly for those in the audience, that
18 because of the setup and the venue here, it may be a
19 little awkward for you. The screen is over here on my
20 right and about in the middle of the room, so those
21 near the front may have to do a bit of twisting and
22 turning to see the screen.

1 Chris, glad to have you here today. Please proceed.

2 **MS. ELLISON:** Good morning. Can everyone hear me okay?

3 **UNIDENTIFIED:** No.

4 **MS. ELLISON:** Okay, before I proceed --

5 **DR. ZIEMER:** No.

6 **MS. ELLISON:** No?

7 **DR. ZIEMER:** Maybe a little closer, or they'll turn it up a
8 little, perhaps.

9 **MS. ELLISON:** Better?

10 **DR. ZIEMER:** Yes.

11 **MS. ELLISON:** Much better. This morning I'll be presenting
12 the current program overview, and it's very similar to
13 a lot of the format that you've seen before when Dave
14 Sundin has been presenting this -- similar format. And
15 then when I get done with this presentation, I also
16 would like to show you a web page that we're working
17 on. It's a different look at a lot of the program
18 stats that we currently have.

19 **MR. ELLIOTT:** Chris, if you put that on the right side, when
20 you talk to the -- the screen, it'll pick your voice up
21 better.

22 **MS. ELLISON:** Better? Now as you know, we have started

1 receiving cases from the Department of Labor back in
2 October of 2001, and this slide here shows the number
3 of cases that we've received currently, based on each
4 year. And at the current time, we're just under 15,000
5 cases that we've received from the Department of Labor.

6 And if things go at the current rate, it does appear
7 that we'll probably hit 15,000 probably by the end of
8 December.

9 Now with those 15,000 cases that we have received, the
10 number of cases that are considered Atomic Weapons
11 Employer, or AWE, cases are just over 2,000, which is
12 roughly still 14 percent, which is what it's been
13 running now for quite some time. And then the number
14 of cases that are non-AWE employees, which are the
15 Department of Energy employees, is just a little more
16 than 17,500 (sic).

17 Now if you do your math real quick with those two numbers --
18 when I was putting together the presentation I added
19 those numbers and I thought that doesn't quite add up to
20 the 14,895 that we're showing, so I did a little bit of
21 investigative work, wondering why that was occurring,
22 and I was told that more than likely the Department of

1 Energy has sent us some beryllium cases that we should
2 not have had.

3 Which leads me into the last number on this slide, which is
4 the number of cases that we currently have in process
5 or in-house that we're working on the dose
6 reconstructions, which is just a little over 13,500.
7 And those numbers are the active cases. It does not
8 include cases that we have returned to the Department
9 of Labor because we've completed the dose
10 reconstructions. And there are some cases that are
11 sent to us by mistake, which would include the
12 beryllium cases, and sometimes we receive duplicate
13 cases. So that 13,563 is actually what we have in-
14 house and we're working on the dose reconstructions
15 right now.

16 This is a trend chart, and I know you've seen it before,
17 also. And what I've done is I've updated the fourth
18 quar-- or the first quarter of fiscal year 2004. And
19 based on this, you can see that the numbers are still
20 continuing to decline in the number of cases that we
21 receive from the Department of Labor. However, it does
22 average out -- this is based at the end of November.

1 It is still averaging out just slightly over 200 a
2 month.

3 One of the first things that happens to the cases when we
4 receive them from the Department of Labor, we do have
5 to scan everything in that we receive and put it into
6 the electronic database that we have. Once that is
7 completed, the next thing that we do with the case is
8 we do send a request to the Department of Energy for
9 the exposure monitoring information. And this here
10 shows the number of requests that we have currently
11 sent to the Department of Energy, and that's just over
12 14,000 requests. That does represent roughly 12,700
13 claims or cases that we have. And keep in mind that a
14 lot of these cases, if someone has worked at multiple
15 sites, we do have to send out more than one request to
16 cover all of the sites that they have worked at.

17 Thus it gets to the next item up there, the responses we've
18 received. And that's why that's a little bit higher
19 than the number of total requests that we've sent out,
20 which the responses now at almost 22,000. That
21 accounts for the multiple sites that individuals have
22 worked at, and then also sometimes the Department of

1 Energy sends us more than request -- or response to our
2 request. They'll send it in partial pieces.
3 The last item on this slide shows the number of outstanding
4 requests that we have. We do ask that the Department
5 of Energy try to fill our requests within 60 days, and
6 we have been working with them in trying to get those
7 requests in a timely manner. And here are some points
8 and some days that the numbers are showing of the
9 number of cases that are currently at those 60, 90, 120
10 and 150 days.
11 But I want to draw your attention to this next slide. I
12 know this next slide -- you normally see it with some
13 percentages off to the side, and I wanted to pull the
14 percentages off to kind of make the numbers pop out and
15 stand out a little bit more. And I do want to note a
16 few things about this. We've been saying that we're
17 continuing to see a little bit better response rate in
18 getting the information to us in a more timely manner
19 from the Department of Energy. And a couple of the
20 sites I want to note that are on here have increased
21 their percentage response rate from October. Savannah
22 River Site in October they were showing a 78 percent

1 response rate; they are now showing an 86 percent
2 response rate, so it has gone up a few percentages for
3 Savannah River.

4 Richland has also increased their response rate. It went
5 from a 94 percent to a 98. Nevada Test Site, two
6 percent increase; it went from a 97 to a 99 percent.
7 And the last one that showed a fairly significant
8 increase was the Idaho Operations Office, and they went
9 from a 57 percent response rate to -- or a 50 percent
10 response rate, excuse me, to a 57, so the continued
11 meetings that we do have with the Department of Energy
12 appear to be working. We must keep in mind also that,
13 you know, the Department of Energy had to get their
14 programs up and running in order to provide us these
15 responses, so it does show that they are responding to
16 the requests.

17 Now the telephone interviews. As you know, the Act did not
18 require that we conduct individual telephone interviews
19 with the claimants, but we felt we wanted to build it
20 into the process because it gave the -- gives the
21 claimant the opportunity to provide us with any
22 additional information that they may be aware of that

1 will help us in doing the dose reconstruction for their
2 case. So currently our contractor, Oak Ridge
3 Associated Universities, is working on the telephone
4 interviews for us. And if you look, they've conducted
5 at least one telephone interview for almost 9,000
6 cases. And with -- once the telephone interview has
7 been conducted, we do send a summary report to the
8 claimant, and we ask them to review the summary report
9 and provide us with any updates or corrections that
10 they may see. And I'm showing that not quite 11,500 of
11 those summary reports have been sent out. And the
12 current capacity that ORAU is showing in conducting the
13 interviews is still maintained at about 200 to 300 a
14 week.

15 Now the information that everyone's been waiting on, the
16 dose reconstructions. In previous presentations there
17 was one category called cases initiated. We now have
18 the ability to break that into two different parts, and
19 the first one is cases staged for dose reconstruction,
20 which is roughly 2,700. What this means is these are
21 cases who have all their telephone interviews
22 completed. We have received dose information to do the

1 dose reconstruction. We've sent them a letter telling
2 them that we've received all that information and, if
3 applicable, a site profile has been completed for their
4 site. Those cases are ready to be assigned.

5 Therefore we have the next number is the number of DRs
6 assigned. These are one -- cases that are currently
7 assigned to a health physicist and we are working on
8 the dose reconstructions, and that is at 631.

9 The number of draft reports that are sent to a claimant are
10 just about at 250, and those are ones where we've sent
11 the dose -- draft dose reconstruction report to the
12 claimant and asked them to review it. We will conduct
13 a close-out interview with the claimant to explain the
14 draft dose reconstruction report to them. And we also
15 send at that time the OCAS-1 form and asking them to
16 sign that and return that to us.

17 And the last figure for the dose reconstruction statistics
18 are the final ones sent to DOL. We also do send a copy
19 to DOE, and those are just at over 1,000. Actually I
20 called this morning. That number's gone up slightly.
21 It's at 1,045. I wanted to see -- I did these stats
22 Friday morning. I wanted to see how much it changed

1 over the weekend at the end of that day.

2 The phone calls and the e-mails that we receive -- one thing
3 that I reported last time at the October meeting was
4 that we were going to be sending out an activity
5 report. And if you look at the numbers -- there are
6 large numbers that are up here. OCAS phone calls are
7 almost at 26,000. ORAU phone calls are right around
8 53,000. And there's a little bit of a reason for that
9 difference. The phone calls that OCAS primarily takes
10 are claimant calls, and ORAU contractor -- they do set
11 up telephone interviews, and each time they attempt to
12 contact a claimant, that is logged into our database.
13 So that can account for why their numbers are slightly
14 higher.

15 However, since we did send the activity report out, I know
16 that our public health advisors within OCAS have
17 commented that the phones haven't been ringing quite as
18 much, and I did look and they're down from -- let's
19 see, October to November, the phone calls are down
20 about 600 each month. They're a slight decline there.

21 And the e-mails are pretty constant, still coming in and
22 total within the system is just over 2,700 (sic).

1 And now the recent accomplishments that we've had with the
2 program since the last meeting. In November we did
3 appoint 36 additional physicians to the DOE physician
4 panels, which brings the total to 159. Also, the
5 residual contamination final report was released, and
6 it is available on our web site. And I did mention the
7 third item, we hit a milestone -- I believe it was last
8 week -- with the 1,000 DRs completed and sent back to
9 the Department of Labor.

10 Now the last item on here -- these are also available on the
11 web site -- are the various site profiles. And we have
12 been publishing them and putting them on the web site
13 once the items are available. From the time of the
14 October meeting until now, we've placed several new
15 documents on the web site, and I did try to remember to
16 send an e-mail to the Advisory Board to let you know
17 when this has been done. We've added an AWE and a DOE
18 site-wide documents, I believe there are two for the
19 DOE facilities. Also the Hanford site profile is now
20 complete. I just posted the introduction on the web
21 site. There is now a site profile for the Huntington
22 Pilot Plant and with INEEL, Portsmouth and X-10, we

1 posted part of the site profile. It was -- the site
2 description has been posted, and the other pieces are
3 now pending. And then we have Y-12 with the site
4 description and the dosimetry.

5 That's all I have basically for the stats. Are there any
6 questions before I go on?

7 **DR. ZIEMER:** Thank you, Chris. Let me begin with a couple
8 of points for clarification.

9 **MS. ELLISON:** Sure.

10 **DR. ZIEMER:** The slide number -- I think it's slide six, you
11 have interview summary reports sent to claimants,
12 11,499.

13 **MS. ELLISON:** Uh-huh.

14 **DR. ZIEMER:** And you also listed cases for which one or more
15 interview is completed, 8,954. Clarify the difference
16 in those two numbers.

17 **MS. ELLISON:** The 8,954 represents the number of telephone
18 interviews for at -- at least of which one interview is
19 conducted.

20 **DR. ZIEMER:** One or more.

21 **MS. ELLISON:** At least one.

22 **DR. ZIEMER:** Right.

1 **MS. ELLISON:** Right, and with a lot of the cases there are
2 multiple survivors, each survivor or applicant has the
3 opportunity to participate --

4 **DR. ZIEMER:** So there are multiple summaries --

5 **MS. ELLISON:** Right.

6 **DR. ZIEMER:** -- in some cases then.

7 **MS. ELLISON:** That 8,954 represents per case --

8 **DR. ZIEMER:** Gotcha.

9 **MS. ELLISON:** -- that's the total number of cases.

10 **DR. ZIEMER:** Okay.

11 **MS. ELLISON:** Where the summary is total numbers of summary,
12 not...

13 **DR. ZIEMER:** And then on the next slide where you give
14 number of draft reports sent to claimants, I assume
15 that's just the number that are currently out there --

16 **MS. ELLISON:** Right, that we're waiting --

17 **DR. ZIEMER:** -- that last column, final draft reports, at
18 one time -- or the final -- the final reports, not
19 draft --

20 **MS. ELLISON:** Uh-huh.

21 **DR. ZIEMER:** -- at one time were drafts, so that this 249
22 drafts is just what's currently --

1 **MS. ELLISON:** Right, that's currently what we're waiting on
2 that OCAS-1 to come back. There's 249 out there.

3 **DR. ZIEMER:** Thank you.

4 **MS. ELLISON:** Uh-huh. One more thing -- any other questions
5 on the slide presentation?

6 **DR. ZIEMER:** There's one question here, start with Bob, then
7 we'll come down.

8 **MR. PRESLEY:** Do you think --

9 **DR. ZIEMER:** Use the mike, Robert.

10 **MR. PRESLEY:** Robert Presley. Chris, do you have any reason
11 why that Savannah River and Idaho and Los Alamos -- has
12 DOE given you any reason why that they've got so many
13 that are better than 150 days?

14 **MS. ELLISON:** I know that we have been in contact with them
15 and we are working with them and they are setting up
16 their systems. A lot of those -- those three that you
17 named off, I didn't provide their percentages because
18 they're maintaining the constant level from the last
19 time, so -- I do know that we are working with them in
20 trying to get those, and have identified specifically
21 which of the cases that we're waiting on so they are
22 aware of that and they are working on them.

1 **MR. PRESLEY:** Thank you.

2 **MS. ELLISON:** Uh-huh.

3 **DR. ZIEMER:** Okay, Jim?

4 **DR. MELIUS:** Yeah, just to follow up on that, the -- those -
5 - you have a large number of cases that are over 150
6 days for those -- I think those three sites that were
7 just mentioned. Are those sites -- I take it those go
8 -- are any of those ever getting cleared or is that
9 just sort of a steady, you know, number --

10 **MS. ELLISON:** No, we are receiving --

11 **DR. MELIUS:** -- constant -- but -- but are we receiving --
12 are -- is there a group out there that they're not
13 finding records on or are they just -- is that just a
14 question of the flow through the system as things come
15 back from -- 'cause that's a long time for a claimant
16 to wait and --

17 **MS. ELLISON:** Right. In the monthly reports we do specify
18 which claims or cases that we are waiting on the
19 information, and we do require the Department of Energy
20 to send us a response saying no, they cannot find any
21 information. So in those cases they have not indicated
22 that they cannot find anything.

1 **DR. ZIEMER:** I think Larry has some additional comments and

2 --

3 **DR. MELIUS:** Yeah, let me ask one additional point 'cause
4 then Larry can answer them both. Is the Iowa -- the
5 Iowa site, which isn't listed there, but if -- as I
6 recall from a couple of meetings ago, there was a major
7 problem in getting records from that site and has that
8 been resolved?

9 **MS. ELLISON:** Yes, it has. I'll let Larry answer that.

10 **MR. ELLIOTT:** To your first question, let me respond that
11 some of those numbers that you see there are static.
12 They've been there from the start and we're working on
13 those individual cases with that respective site to
14 understand better what is going on. And in some cases,
15 yes, they are having trouble even verifying that the
16 person actually, in their records, worked at the site,
17 perhaps, because they might have been verified by Labor
18 as having worked at the site by IRS records or some
19 other sort of record system. The majority of those --
20 those numbers that you saw, though, change. It's a --
21 it's a small group that we see as static, and we're
22 working on all of the numbers.

1 The Idaho site had to index -- had to scan all of their
2 boxes of records -- thousands of boxes of records, and
3 then index through that scanning effort so that they
4 could retrieve a person's history of dose. And that
5 took a while to do and that has been completed. And in
6 fact, our ORAU team has aided the Idaho site by
7 providing some further contract support to people who
8 are working on that indexing effort who are now
9 searching for those records for those individuals. So
10 we've accommodated that through that particular site.

11 Now to your second question, the Iowa plant, yes, that -- we
12 have I think received five or six boxes of records that
13 were held by the Department of Defense, and that's been
14 very critical. They're in the hands of the Technical
15 Basis Document team right now going through that
16 information. So we're working each one of these
17 situations independently and as best we can.

18 **DR. ZIEMER:** Yeah.

19 **MR. GRIFFON:** Yeah, I just had a question -- or a couple of
20 questions. First one's on the telephone interview.

21 **MS. ELLISON:** Uh-huh.

22 **MR. GRIFFON:** It says 200 to 300 per week. Do you know how

1 many interviewers on average are doing -- are
2 conducting the interviews?

3 **MS. ELLISON:** I might have to ask Dave to answer that. I
4 know --

5 **MR. GRIFFON:** Ten? Is that the --

6 **UNIDENTIFIED:** About ten.

7 **MR. GRIFFON:** Ten?

8 **MS. ELLISON:** About ten?

9 **MR. GRIFFON:** And is there -- has there been any effort --
10 maybe Dick can answer this, too, as -- are -- are there
11 certain people who are doing certain sites? Are you
12 grouping them with interviewers that have expertise or
13 knowledge of certain facilities or how -- how is that
14 being...

15 **DR. ZIEMER:** Okay, I think Dick Toohey may be able to
16 respond to this. There -- is that mike working? Yes.

17 **DR. TOOHEY:** (Off microphone) Is this one on?

18 **MS. ELLISON:** No.

19 **DR. ZIEMER:** Is there a mike we can use for --

20 **MR. ELLIOTT:** He's got it working now.

21 **DR. TOOHEY:** Okay, yeah, there we go. Okay. Actually we
22 have a total of 16 interviewers, but with, you know,

1 vacation, things like that, the average working a day
2 is probably 12 to 14. Our goal has always been to get
3 them to be site-specific. But since we're still in
4 kind of what I'll call a batch mode where we're --
5 we're trying to knock all the Hanfords out, all the
6 Savannah Rivers out, the sites where we have the site
7 profiles completed -- we're not really doing that yet.

8 **MR. GRIFFON:** Okay. Just one more. On the slide before
9 that, you talked about the data requests to DOE and the
10 percentage of responses, and I think -- I've tried to
11 ask this before and I'm not sure how clear I was, but
12 first of all, does -- do those statistics include data
13 requests for information that might be used for the
14 site profiles, or is that only for personal dosimetry
15 records or...

16 **MR. ELLIOTT:** It's only -- those numbers represent the
17 requests that we've sent for personal dose information.
18 The requests that we've made to DOE for site profile
19 is tracked in a separate system.

20 **MR. GRIFFON:** So anything in here, it's fair to say, is
21 personal dosimetry or medical records or work history
22 records or those sorts of things. Right?

1 **MR. ELLIOTT:** Dosimetry records, not medical records. Not
2 medical. Dosimetry records -- there may be -- in those
3 numbers there may be requests for -- if they couldn't
4 find personal monitoring information, there might be a
5 request for co-worker data or alternate -- you know,
6 the hierarchy of data that we seek.

7 **DR. ZIEMER:** Okay. Tony Andrade, and then back to Roy.

8 **DR. ANDRADE:** I just wanted to comment that one thing we
9 should not forget is that dosimetry records are
10 difficult, in and of themselves, to understand and to
11 send back in the appropriate format for dose
12 reconstruction, especially in the case of inhalation.
13 Way back in the early days we used to have limits
14 imposed on us in terms of body burden, and so some of
15 the data that were recorded were in terms of
16 percentages of body burden. Then in the early 90's --
17 well, after World War II and then on into the 90's,
18 dosimetry records for, in particular, inhalation
19 uptakes were kept in terms of annual doses. So those
20 are easy. Those are easy if you're talking about an
21 employee at a -- at one facility, who's never worked
22 elsewhere.

1 When you start to have to add records from places that an
2 employee may have worked, then that becomes a little
3 bit more difficult.

4 Then after about the early 90's, legislation was passed such
5 that we had to maintain those type data in terms of
6 committed effective dose equivalent. That's a 50-year
7 dose. It's basically an exponential function of the
8 dose that you will receive within your body of the
9 radionuclides as they sit there and decay. So given
10 that NIOSH requires these data in terms of annual dose,
11 they have to go back and work with that function and go
12 back and formulate and formulate it in terms of years.

13 So when somebody says oh, how come these people aren't
14 responding so quickly, just factor that into your
15 thinking, especially at Los Alamos where we worked with
16 uranium and with plutonium and have kept records for
17 people coming in from other facilities. Let me just
18 say it's not an easy process to send back dose records
19 very quickly for one person.

20 **DR. ZIEMER:** Okay. Comment or response from Larry, and then
21 we'll go to Roy.

22 **MR. ELLIOTT:** I appreciate Dr. Andrade's comment, but I

1 would -- I feel the need to clarify something. We
2 don't ask for annual cumulative dose. We ask for the
3 raw numbers that were used to build that annual
4 cumulative dose, and I think that even goes further to
5 add to the difficulty of providing a response to our
6 request, because we need -- you know, if the badge
7 exchange frequency was a monthly basis, that's what we
8 want to see. If the bioassay was done on a quarterly
9 basis or an annual basis or what have you, we want to
10 see the raw numbers. That's what we're after.

11 **DR. ZIEMER:** Thank you. Okay, Roy.

12 **DR. DEHART:** In the presentation you indicated that the
13 final dose reconstruction was sent to the claimants
14 approximately -- a little over 1,000. What kinds of
15 responses are coming in from those claimants who are
16 receiving those doses?

17 **MS. ELLISON:** In the finals?

18 **DR. DEHART:** On the finals, yes.

19 **MS. ELLISON:** As far as I -- once -- it's a final copy of
20 the report to let them know that it has been forwarded
21 then to -- to the Department of Labor for final
22 adjudication.

1 **DR. DEHART:** Are they making any comments in -- back to you
2 as to correct or --

3 **MS. ELLISON:** Not on finals that I'm aware of. I would
4 think minimal -- you may --

5 **DR. ZIEMER:** Yeah, let me ask either Larry or Dick Toohy --

6 **MS. ELLISON:** -- need to ask...

7 **DR. ZIEMER:** -- also to address that. I think they do have
8 the opportunity to comment on that, so what -- I think
9 that's the question, are we -- are we in fact getting
10 comments and what are the nature of those.

11 **MR. ELLIOTT:** Yeah, and I think Dr. DeHart's question is on
12 the OCAS-1 stage --

13 **MS. ELLISON:** Right.

14 **MR. ELLIOTT:** -- because that's the stage where we send a
15 draft dose reconstruction report to the claimant with
16 this OCAS-1 form that they are asked to sign off on,
17 which imparts that they have no further information to
18 provide and allows us then to move the complete dose
19 reconstruction over to the Department of Labor. We do
20 hear comments back at the OCAS-1 stage. A lot of
21 people -- it runs the gamut from thank you, I finally
22 have an answer, to I don't agree with what you've done,

1 to writing things on the OCAS-1 that have no bearing on
2 the case but we have to take that into account. And
3 this is all captured and tracked in the administrative
4 record, so it runs the gamut. I would offer that the
5 majority of OCAS-1's that are returned to us are simply
6 signed off on and -- and that's it. We don't have any
7 further -- further commentary that is provided at that
8 point.

9 **DR. ZIEMER:** Okay. Mike Gibson.

10 **MR. GIBSON:** Just another comment that complicates I think
11 the issue of the dose reconstruction is at least some
12 of the sites, if not all, when the records were kept
13 some years ago it was just recorded in gross alpha, not
14 specifically the radioisotopic -- that was -- that was
15 used, so it could -- it could make a difference in the
16 dose consequence.

17 **DR. ZIEMER:** Thank you. And certainly the internal dose
18 issues are complex, depending on the site.

19 Any further comments?

20 **MR. ELLIOTT:** Chris has a little more to show.

21 **DR. ZIEMER:** Okay, Chris, you have some additional --

22 **MS. ELLISON:** I have one more piece --

1 **DR. ZIEMER:** One more piece.

2 **MS. ELLISON:** -- if you'll bear with me. Currently on our
3 web site we have a claim information page, and if you
4 have looked at it, it gives running totals for the
5 various steps in our dose reconstruction. Our -- the
6 director of NIOSH, Dr. Howard, has requested and wanted
7 to see specifically of the cases we have in-house just
8 where are they in our system. So we've developed a
9 flow chart and we're currently working on developing it
10 and getting it on the web site, and I plan on sending
11 screen shots to the Board once it's a little bit
12 further along, so you'll see this before it goes up on
13 the web site.

14 Basically it breaks down the cases that we have in-house and
15 shows which individual step the cases are in. And with
16 each of the steps, you can click on the boxes and there
17 will be a breakdown then of the information contained
18 on the site. The gather exposure information -- I'm
19 having a hard time getting it to scroll down for me,
20 there we go. Oh, it does break -- we have most of the
21 information broken down into the four district offices
22 that we receive the information from, but we're hoping

1 that this will kind of show the public a little bit
2 better specifically where that 14,000-plus cases are in
3 our system, how many of them are actually waiting on
4 the exposure information, how many of them are at the
5 telephone interview stage. And that's primarily just
6 what I wanted to show you, the draft DR's and things.

7 Any questions?

8 **DR. ZIEMER:** Jim?

9 **DR. MELIUS:** Yeah. I don't think most people out there
10 really care about the DOL district offices. Is there
11 any way you can break it down by site? I know people
12 work at more than one site, but how you count that gets
13 a little complicated, but it certainly would be a more
14 meaningful --

15 **MS. ELLISON:** Okay.

16 **DR. MELIUS:** -- number for people to --

17 **MS. ELLISON:** Like I said, right now we're working on that -

18 -

19 **DR. MELIUS:** I understand, I'm just saying --

20 **MS. ELLISON:** -- (Inaudible) right, and those are the type
21 of comments we're looking for.

22 **DR. MELIUS:** 'Cause I think that would be -- help -- help

1 people, and if there's a way you could array the -- a
2 screen that would have the -- the different steps and
3 the numbers and just as a table that people could look
4 at quickly by site, maybe it's another -- another page
5 or something that would --

6 **MS. ELLISON:** Okay.

7 **DR. MELIUS:** -- with the sites down the left-hand column --

8 **MS. ELLISON:** Thank you.

9 **DR. MELIUS:** -- I think that would be helpful.

10 **DR. ZIEMER:** Thank you, good suggestion. Any other comments
11 or suggestions? Henry?

12 **DR. ANDERSON:** Just one. That would be -- we're on our
13 number 19 meeting, and I guess one thing that would be
14 helpful is it's nice to see the numbers changing and
15 advances being made, but it's hard to come up with an
16 overview as are we catching up, are we further --
17 falling further behind. The process seems to be now
18 kind of in play, the number of requests coming in are --
19 - appear to be going down, but with 504 in the last
20 quarter, it just -- grossly it appears to me as though
21 we may be falling even further behind, so it'd be nice
22 if we could have some kind of a summary of what changes

1 have been made, you know, what new is coming in --

2 **MS. ELLISON:** Uh-huh.

3 **DR. ANDERSON:** -- and you know, how many we -- we can see
4 how many are going out, but where do we stand on the
5 overall program of -- can we say we're starting to eat
6 into that backlog?

7 **MS. ELLISON:** Okay. Thank you.

8 **DR. ZIEMER:** Other comments, suggestions?

9 **MS. ELLISON:** And as I said, I plan on sending screen shots
10 of the various screens for further comment and for
11 further review.

12 **DR. ZIEMER:** Thank you.

13 **MS. ELLISON:** Uh-huh.

14 **DR. ZIEMER:** Okay. We appreciate your presentation, Chris.

15 **MS. ELLISON:** Thank you.

16 **STATUS REPORT - DEPARTMENT OF LABOR**

17 **DR. ZIEMER:** The next item on our agenda is a status report
18 from Department of Labor. Jeff Kotsch is here this
19 morning with us and he'll make that presentation.
20 Jeff.

21 **MR. KOTSCH:** I think it's on, isn't it?

22 **DR. ZIEMER:** Yeah, it's on.

1 **MR. KOTSCH:** Good morning. My name's Jeff Kotsch. I'm the
2 health physicist with the Department of Labor's
3 program. Pete Turcic was unable to attend this morning
4 because he has a DOL management meeting this week, but
5 we pretty much promise you'll see Peter next time, so
6 hopefully that'll be the case.

7 We're -- all of this data is pretty much current as of
8 November 27th of this year, and one problem that we
9 wrestle with is always trying to synchronize with --
10 trying to get our numbers to kind of match NIOSH
11 numbers, and I know it drives my bosses, both Pete and
12 Shelby, crazy when we can't come up with the exact
13 numbers, but I don't know that we'll ever get there,
14 but we'll -- I think we're fairly close. But you just
15 have to keep that in mind.

16 The total number of claims received to date or as of
17 November 27th is 49,113. The first five categories up
18 there are primarily the ones that are covered under the
19 statute, and the last one, the other, is -- is the ones
20 that are not. Those are the respiratory conditions
21 that we get -- the COPD's, the asbestosis, the heart
22 conditions, things like that -- things that are not

1 covered by the statute.

2 The bulk of the ones that are covered are primarily cancers,
3 33,766, and then the rest are -- as indicated there --
4 the beryllium sensitivities, the CBD -- the chronic
5 beryllium disease, the silicosis and the RECA
6 compensation that's part of the Department of Justice
7 program.

8 Now one thing during this presentation, we're shifting
9 between cases and claims, and just so you get -- have
10 to keep in mind again that the cases -- there's one
11 case for every employee, but there's -- and if the
12 employee's still surviving, he's the claimant, but if
13 he's deceased then you either have a spouse or one or
14 more children as a claimant so the claimant number is
15 always -- or the number of claims is always greater
16 than the number of cases.

17 So there's just, reading left to right, the case status in
18 the Department of Labor, 14,838 cases that were sent to
19 NIOSH as of November 27th. Recommended decisions were
20 issued by the four district offices, a little over --
21 about 21,400. And if you go over -- well, I'll just go
22 left to right. Pending final decisions, about 1,500.

1 Those would be in our FAB -- the final adjudication
2 branch -- in the four district offices, as well as our
3 national office. And then the FABs also issued about
4 19,900 decisions.

5 Pending action, the second from the right, about 1,500 cases
6 are still pending some kind of review in our district
7 offices. And then the total number of cases is 37,192.

8 For the final decisions, the claim approval is 10,729 and
9 denial is 14,324, and then the recommended decisions
10 are about 11,200 for approval and claims denied of
11 about 16,500. Again there's the NIOSH -- the number of
12 cases sent to NIOSH, the payments issued as of November
13 27th are 9,483. The amount of compensation is \$700
14 million 474,000 or 475,000. The amount of medical
15 benefits paid is \$21 million about 205,000. And
16 there's a summary of the total claims, the total cases.

17 The initial decisions, these are the point at which we
18 either -- when we consider initial decisions, the point
19 where we either have gotten to the point where we send
20 the case on to NIOSH for dose reconstruction or, if
21 it's not a cancer case or it's something we can
22 continue adjudication on -- the SEC cases, the

1 beryllium cases, the silicosis cases and the -- and the
2 ones that are covered under the (Inaudible), but any
3 one that referring for -- I'm sorry -- so anyway,
4 recommended decisions for 27,000 about 700 claims,
5 recommended decisions for the -- of that 21,000 about
6 400 cases. So at that point we're about 96 percent
7 completed as far as the process goes to get to the
8 initial decision, either forward it to NIOSH or just to
9 continue with the recommended decision.

10 Again there's a summary of the claims and the cases. The
11 final decisions, with 25,053 claims of which there's
12 19,835 cases. And there's the percentage of final
13 decisions, about 53 percent. And the bulk of those
14 would be the NIOSH cases that are still awaiting some
15 decision as far as going to a final decision.

16 That's just the breakdown of the way the claims are. That's
17 the 25,053 total claims distributed (Inaudible) down
18 10,729 finals approved, 14,324 denied. The bulk of the
19 denials is that purple column there. Those are the
20 non-covered conditions -- the respiratory, the heart,
21 the other types of conditions that are not covered
22 under the statute. And then in decreasing order, the -

1 - 2,318 for the employees that are not covered at -- or
2 worked -- had worked at covered facilities, ineligible
3 survivors, conditions not related to employment,
4 insufficient medical evidence, and then cancers not
5 related with POC's less than 50 percent.

6 As far as processing time, I think the last time we went
7 through by quarter the processing times for the last
8 year and we saw that as far as the Department of Labor
9 that the percentages were coming below our target goals
10 and continue to be that way. For the last quarter the
11 average initial processing time for the AWE, beryllium
12 vendor, DOE subcontractor claims is 103.5 days versus a
13 goal of 180 since we assumed that it's harder to --
14 it's -- it has taken longer to get that information.
15 The average initial processing time for the DOE and
16 RECA claims is about 76 days against a target of 120
17 days.

18 Status of the referral of the 14,000 -- what we see as the
19 14,838 claims and cases that have gone for NIOSH
20 referrals as of the 27th of November, the cases --
21 we're showing 100 -- or I'm sorry, 1,146 cases returned
22 from NIOSH. I think the NIOSH number is lower. Then

1 again this is one of our disconnects I know we're
2 working on with our systems people to look at these
3 cases and to see how we report these things between
4 ourselves and how -- I guess also how we're looking at
5 what constitutes cases. And those are the breakdowns
6 for the completed cases returned to NIOSH -- cases with
7 recommended decisions, we have had 863, the acceptance
8 is 321 of those, 542 denied. Cases with final
9 decisions, 478, of which a little more than half, 254,
10 have been accepted as of November 27th. That's the end
11 of this.

12 The one thing I just wanted to comment on is the last time
13 we spoke about -- or you asked questions about -- or
14 DOL outreach activities. Pete mentioned to me -- when
15 I went back I talked to Shelby and Pete. We certainly
16 are doing outreach. We have developed a plan for that
17 and Pete asked me if he could just present that at the
18 next meeting, that would be fine. So if there are any
19 questions?

20 **DR. ZIEMER:** Thank you, Jeff. Do you have any specific
21 numbers on the number of SEC cases that have been
22 processed?

1 **MR. KOTSCH:** No. I mean I don't -- not with me. I -- this
2 is not -- the case numbers are things that I don't
3 normally deal with as part of my job, and I'm just
4 trying to think back to the statistics I've seen. I
5 don't know whether --

6 **DR. ZIEMER:** It seems to me that might be of interest to us
7 to -- maybe next time --

8 **MR. KOTSCH:** I certainly -- I know we -- I know we break
9 those numbers --

10 **DR. ZIEMER:** I'm sure you have the numbers. I think it
11 would be of interest to this Board to know how many SEC
12 cases have been processed and --

13 **MR. KOTSCH:** Yeah, we can do that.

14 **DR. ZIEMER:** -- and approved. Leon, a question?

15 **MR. OWENS:** The initial processing claims time, is that
16 inclusive of the time that it takes DOE to do the
17 records retrieval, or is that excluded?

18 **MR. KOTSCH:** That includes the time that we get -- well,
19 that -- that does include the time for us to get answer
20 back from DOE as far -- at least as far as employment
21 goes. And certainly -- I mean the NIOSH process is
22 more of -- time-consuming because they're going out for

1 another document retrieval that's more extensive than
2 the one we have. And we also default -- sometimes if
3 we don't get a response back by -- from DOE in a
4 sufficient amount of time, we'll default to other
5 mechanisms like Social Security and things like that to
6 confirm employment 'cause we're primarily after
7 confirming the medical conditions and confirming
8 employment.

9 **MR. OWENS:** Okay, so in the event that you don't receive the
10 records from DOE in what the Department feels is a
11 timely manner, then you would resort to other agencies
12 in order to try and verify that employment?

13 **MR. KOTSCH:** Yeah, I mean we continue to ping DOE as far as,
14 you know, trying to get a response one way or the other
15 from them that they either do not have records or
16 they're unable to provide records, and then we'll move
17 forward. I mean we continue to seek from them the
18 records that -- but we try to get the response back
19 from them that they -- that they do not have records
20 before we move on to the Social Security or union labor
21 -- labor records or things like that.

22 **DR. ZIEMER:** Tony and Jim and Gen.

1 **DR. ANDRADE:** Once a case has been considered to be at what
2 you call initial decision, what is the time between
3 that point and the point that the case is sent to
4 NIOSH? And also I'm just curious, how is the case sent
5 to NIOSH? Is it just a direct digital transfer or some
6 other means?

7 **MR. KOTSCH:** No, the -- what -- when a case -- for the NIOSH
8 cases, basically once we've developed the information
9 on employment and medical condition, there's no real --
10 as soon as that's assembled, that information is now
11 transferred to NIOSH. There's no -- I don't -- I don't
12 know how to ascribe a time to that. When it is
13 transferred, it's unfortunately transferred as a hard
14 copy. The case file is copied by Department of Labor
15 and a copy goes to NIOSH. We have looked in the past
16 to -- especially with the NIOSH referral summary
17 document, which is our basically summary of the case,
18 transferring that to NIOSH digitally so at least that
19 would -- that could -- that could be done and we're
20 still looking into that. But our two systems
21 unfortunately are not highly -- our computer systems
22 are not really compatible with one another.

1 **DR. ZIEMER:** Jim?

2 **DR. MELIUS:** Going back to the SEC case issue, one of the
3 things that we talked about many meetings ago and I
4 think it may be useful to tie together in this context
5 is that there are also a number of cases that -- from
6 the SEC sites that don't meet the criteria in terms of
7 the amount of time worked, that sort of overlap between
8 the SEC program and the NIOSH program, and at some
9 point there's some issues with how -- how those are
10 going to be dealt with that we have decide on --
11 presumably also at some point Ted Katz'll finally get
12 his job done and we'll have SEC regs out there and
13 we'll be able to -- I think that's one of the issues we
14 have to deal with, so it may be a way of tying this all
15 together that I guess is what I'm proposing to -- that
16 we as a Board need to be thinking about, and NIOSH
17 does, also. And I think it would be helpful if we knew
18 the numbers involved in this overlap area and in some
19 of the situations so we can sort of think about how to
20 -- how to approach it.

21 **DR. ZIEMER:** Jim, you're asking about the numbers who don't
22 meet the time requirement at the SEC sites who may have

1 submitted for a claim anyway or --

2 **DR. MELIUS:** Yeah, they've submitted for a claim, they don't
3 meet the time requirements --

4 **DR. ZIEMER:** Time requirements --

5 **DR. MELIUS:** -- for the SEC sites --

6 **DR. ZIEMER:** Which is basically the 250-day -- yeah.

7 **DR. MELIUS:** They fall in between the sort -- the --

8 **DR. ZIEMER:** Yeah, I understand.

9 **DR. MELIUS:** -- you know, are they an SEC, we don't -- we
10 can't really deal with this till we have the SEC regs
11 out, but at that point sort of having the numbers and
12 understanding the numbers involved, the situations
13 involved, I think may help in terms of dealing with
14 this issue.

15 **DR. ZIEMER:** Larry, response?

16 **MR. ELLIOTT:** So you're asking, Jim, for the numbers of
17 cases that were submitted but didn't qualify under the
18 SEC.

19 **DR. MELIUS:** So they come to NIOSH --

20 **MR. ELLIOTT:** They come to NIOSH for dose reconstruction.

21 **DR. MELIUS:** Reconstruction, and there's this issue of how
22 do you account -- how are we going to do their dose

1 reconstruction and...

2 **MR. ELLIOTT:** Well, we are doing dose reconstruction for
3 those cases. We've actually returned several cases for
4 Piketon, Paducah and K-25.

5 **DR. MELIUS:** And we need to look at that issue. That's what
6 I'm saying.

7 **DR. ZIEMER:** Gen Roessler.

8 **DR. ROESSLER:** Jeff, on your slide number four you gave some
9 dollar numbers. It was \$700 million paid out in
10 compensation and about \$21 million in medical benefits.

11 I think -- I'm surprised that the medical benefits is
12 a small fraction of the total compensation and I'm
13 wondering what the reason for that is, a number of
14 claimants have died or...

15 **MR. KOTSCH:** Well, part of it is that if you're -- if you're
16 in a survivor condition, there's no medical payments.
17 It's just a \$150,000 compensation. If you have an
18 employee who's surviving, then he will submit for
19 medical benefits. Early on we were surprised that they
20 were not submitting for medical benefits. There were
21 some problems I think with the health care providers,
22 you know, accepting our -- basically our compensa-- or

1 trying to come directly to use, that's the way we
2 wanted to work it. We didn't want it to have to go
3 through the -- you know, the employee to pay them. We
4 wanted to do it directly, so there were some -- some
5 things there that had to be corrected to move forward.

6 But yeah, we're surprised, too, that the number's a
7 little bit lower than we expect.

8 **DR. ZIEMER:** Henry?

9 **DR. ANDERSON:** I don't remember the actual numbers on your
10 slide, but it appeared there were quite a number of
11 cases where the medical records were insufficient or
12 something like that, and I was wondering what -- what -
13 - what other kind of things that are insufficient? The
14 individual has said that they had a disease and then
15 the record review couldn't document that, and what's
16 kind of the step after that, is -- you know, what
17 further do you do if -- if they say they have it but
18 the hospital has destroyed records or something?

19 **MR. KOTSCH:** Yeah, and that's primarily I think what the
20 issue is. I know I'm looking at a case right now where
21 there's -- you know, the physician came back and said I
22 don't remember exactly treating your husband back in

1 1970 and my office destroyed all the records, you know,
2 after they're ten years old kind of thing. Then you're
3 left basically with -- you know, if the doctor doesn't
4 remember -- the physician doesn't remember, and some do
5 write fairly extensive letters that, you know, well, I
6 don't have records, I -- you know, remember that, you
7 know, I worked with this patient and -- and he had
8 these kinds of conditions over this pa-- you know, over
9 those years. All we can do is ask for affidavits or
10 try to get other information from the medical people.
11 Occasionally -- and we're always amazed that sometimes
12 people have kept their records, even though they've
13 been destroyed by the hospitals but they personally
14 have kept them, which has really been of benefit to
15 them, obviously, when the records unfortunately no
16 longer exist, you know, in the hospital. But yeah,
17 it's a difficult thing for us and -- to try to find --
18 or help the claimant find the medical evidence that
19 provides us with something that substantiates the
20 claim.

21 **DR. ZIEMER:** Jeff, can you speak to us about the numbers of
22 appeals for both NIOSH final decision cases and what I

1 would -- I'll call right now the non-NIOSH, the ones
2 that don't require dose reconstruction, which would
3 include your -- I don't know, any of the other ones
4 that you're handling, but what's the experience on the
5 appeals -- of the denials?

6 **MR. KOTSCH:** Yeah --

7 **DR. ZIEMER:** I assume no one's appealing the acceptances.

8 **MR. KOTSCH:** No, no one appeals the acceptances. I -- and
9 unfortunately, I don't have real good numbers for you.
10 I -- and the only things I really work with, I happen
11 to be the focal point for the technical objections to
12 the NIOSH dose reconstructions, and I've seen about or
13 I have on my desk probably -- I mean have total, since
14 the beginning, maybe 24 or 25 cases that have technical
15 appeals to the NIOSH process. As far as the overall
16 numbers of the objections to the process itself, I'm
17 sure it's much higher because it wouldn't be just -- it
18 would be denials for all the other things and not just
19 the NIOSH cases. We can certainly bring those numbers
20 the next time, as far as both the general objection
21 rate to the FAB decisions as well -- or the recommended
22 decisions, and as well as the ones that relate to the

1 NIOSH (Inaudible) --

2 **DR. ZIEMER:** Well, I don't know if one distinguishes between
3 objections and formal appeals. I mean someone may
4 object, but I'm asking --

5 **MR. KOTSCH:** The appeal -- appeal process is on the final.
6 They have an opportunity at the recommended decision
7 stage to object, and then it goes forward. That's
8 included in -- by FAB into --

9 **DR. ZIEMER:** Is that, what you're calling an objection, kick
10 off an appeal process then?

11 **MR. KOTSCH:** Well, the -- what -- I'm sorry, I should
12 clarify myself. The objections -- when I talk
13 objections, I'm talking mostly at the recommended
14 decision stage. And then they can go into the -- that
15 can be factored into the final decision and at that
16 point is kind of what the appeal process is -- there's
17 a couple of elements --

18 **DR. ZIEMER:** Right.

19 **MR. KOTSCH:** -- you know.

20 **DR. ZIEMER:** And that's what I was asking you about. Maybe
21 someone can let us know next time how that's --

22 **MR. KOTSCH:** Yeah, we can (Inaudible) as far as the fin-- we

1 -- all the things I'm looking as far as technical
2 objections are at the recommended decision stage.

3 **DR. ZIEMER:** Roy, you had a question?

4 **DR. DEHART:** Actually it was just an expansion on the
5 medical record or lack thereof that we're seeing. A
6 panel of three physicians reviews -- currently, at
7 least -- the information that's provided from the
8 Office of Employee Advocacy, and we have seen records
9 that have come to us that have no medical documentation
10 at all. There is no diagnosis that's documented.
11 There is no record of treatment or management. Those
12 are typically elderly people who have passed away and
13 the relative is filing on their behalf, and they have
14 no access -- they don't even know perhaps what hospital
15 or what doctor. And of course there's no way we can
16 move forward with anything on those kinds of -- that
17 lack of information.

18 **MR. KOTSCH:** Those are for the subpart (d) cases --

19 **DR. DEHART:** Yes.

20 **MR. KOTSCH:** -- but yeah, admittedly we see the same thing
21 in the subpart (b) cases.

22 **DR. ZIEMER:** Further questions? Thank you, Jeff.

1 **MR. KOTSCH:** Okay.

2 **DR. ZIEMER:** Appreciate your input this morning.

3 We're a little bit ahead of schedule, but I think we'll go
4 ahead and take our break. Let's -- we can take a
5 little longer than the 15 minutes, maybe about 20
6 minutes or so, then we'll reconvene. Thank you.

7 (Whereupon, a recess was taken.)

8 **SITE PROFILE STATUS AND ROLL-OUT**

9 **DR. ZIEMER:** We can proceed. The next item on our agenda is
10 site profile status, and the -- I'm going to sort of
11 say pinch-hitter, but he's very well qualified, Stu
12 Hinnefeld, who works with Jim Neton on these activities
13 from NIOSH -- and Stu, we're glad to have you here
14 today, and Stu will present the site profile status and
15 roll-out.

16 **MR. HINNEFELD:** (Off microphone) Thank you.

17 (Pause)

18 **MR. HINNEFELD:** So that's it? Okay, sorry. I am really
19 substituting for Jim Neton today. He was unable to
20 travel this week and so I'm here in his stead, and I'm
21 here to present sort of an update on the presentation
22 that he presented at the last meeting about site

1 profile status and the progress that we're making on
2 preparing the site profiles for quite a number of
3 sites, actually.

4 Sort of recapping the information that Jim presented in St.
5 Louis, and also presenting for anyone who hasn't
6 previously seen this or heard about this, site profiles
7 are documents that are used by dose reconstructors to
8 provide consistent interpretation of the information
9 provided from the various DOE sites so we have a
10 consistent understanding of what the bioassay data
11 means, what their bioassay or what their external
12 monitoring technology was, and that allows us to
13 provide consistent dose reconstructions for a
14 particular site. Each particular profile will address
15 one site and one -- perhaps one particular type of
16 exposure -- well, actually each document will. Several
17 documents will be rolled into one site profile. It
18 helps us to minimize individualized interpretation. In
19 other words, we can have a consistent set of rules for
20 interpreting the data. And it's used as a handbook by
21 the dose reconstructors to provide -- to guide them in
22 their work. And they're intended to be dynamic. As we

1 learn more about various sites and their approaches and
2 their technologies, then we may in fact modify the
3 information in the profiles.

4 We are publishing our completed profiles, including the
5 individual pieces of profiles, which we call Technical
6 Basis Documents, as they're approved, on our web page.

7 There is a little bit of a administrative process that
8 happens after one is initially approved. There's a
9 little time lag between the approval and appearing on
10 the web page, but they're all being placed there.

11 We're encouraging comments on these, and if anyone
12 feels compelled to comment on the -- either the content
13 or the proposed application of these site profiles,
14 those comments could be submitted to the NIOSH docket,
15 and there is a specific docket established for each of
16 the approved documents. So again, if you go look at
17 them on the web site, it's fairly apparent there's a
18 link to -- to what has been -- what has been provided
19 to the docket for that -- for that particular document.

20 We are arranging to present the completed documents as
21 they're being completed to union representatives and
22 other interested parties in the vicinity of the

1 affected site. One of those briefings has actually
2 been done since the St. Louis meeting. It was done in
3 November at the Savannah River Site, and the next one
4 is scheduled for Hanford in January.

5 And there's information about the team members for the teams
6 of consultants who compiled these initial versions of
7 the profiles on our ORAU -- our contractor's web site.

8 Now in order to contact the docket or submit comments, here
9 are the ways that you can contact the NIOSH docket
10 office. Written hard copy comments can be sent by mail
11 to the address here. We have telephone and FAX numbers
12 and e-mail that then provides comment to our docket
13 office, and we'll know it is a comment to the docket by
14 using that e-mail address.

15 I might mention that when I was looking at my printed -- the
16 printed copies of my slides, there are a number of
17 spaces that found their way into the slides that don't
18 appear on the slides themselves. And not being very
19 good at this particular software, I apparently wasn't
20 able to get them all out of there, so I apologize for
21 the printed copies of the handout.

22 Our latest status on the site profile status, this again is

1 essentially unchanged from the St. Louis meeting.
2 There are 15 facilities we are working on at the same
3 time. We expect to complete them by the end of the
4 calendar year, and that's getting close. There are
5 very, very many documents that are -- have been
6 reviewed and are in comment resolution and are very
7 close to being approved. And I did not go back and
8 update the percentage of claims, but it's our
9 expectation that these documents will cover very close
10 to 77 percent, or something close to that number, of
11 the total number of claims. In other words, the total
12 number of claims we've received we have to do dose
13 reconstructions from, some 77 percent of them came from
14 this first 15 or so DOE facilities we are now working
15 on.

16 And in addition, since the St. Louis meeting or the last
17 Board meeting, we have completed a couple of complex-
18 wide approaches for processing dose reconstructions.
19 One is for DOE facilities and one is for AWE
20 facilities. These are somewhat limited in their
21 applicability. They obviously can't be applied to all
22 DOE claims or all AWE claims, but there is a set of --

1 a set of claims that do lend themselves to a complex-
2 wide approach for dose reconstruction, and I'll speak
3 more about that in a little while.

4 Site profile status, this was as of November 24th, which was
5 when the -- I had to complete the preparation for the
6 presentation. You can see two of the larger DOE sites,
7 Savannah River Site and Hanford site, those site
8 profiles are complete. And then for several other
9 sites there are either one or two pieces of what I call
10 here as a five-piece site profile. There are about
11 five Technical Basis Documents in each site profile,
12 and then there is a sixth section called an
13 introduction, so I don't really count the sixth as one
14 of the research-oriented pieces of the document, so I
15 entered these as five.

16 After this slide was prepared, a third Technical Basis
17 Document from Y-12 plant was approved, as well, so
18 that's the change as of late last week from this slide.

19 And you also note down here we've completed a DOE
20 complex-wide approach.

21 For AWE sites, I believe this is the same list that was
22 available at the last meeting, except for the addition

1 of the complex-wide uranium AWE facilities.
2 Since we're in Nevada, in the vicinity of the Nevada Test
3 Site, I researched where we were on the sections of the
4 Nevada Test Site profile, the various Technical Basis
5 Documents that comprise that document. The profile
6 initially will consist -- here I go back to the six
7 sections, that sixth section being the introduction,
8 and then the other five sections are site description,
9 what we call occupational medical exposure or X-rays
10 received as a condition of employment like during an
11 annual physical, internal exposures, environmental
12 exposures -- those are all fairly far along and in
13 review and comment resolution. The external dosimetry
14 section is yet to get into the comment resolution
15 stage. It's in our contractor's review stage. And
16 then of course the introductory section, which is sort
17 of just a summation of the information of the other
18 five.

19 Okay, the -- I want to spend a little time describing the
20 complex-wide DOE technical basis. We also did a
21 complex-wide AWE technical basis for a limited set of
22 atomics weapons employers that met certain conditions.

1 First of all, they had to -- their AWE work had to be
2 only with uranium. If there were any other
3 radionuclides associated with their AWE work, then they
4 would -- that -- that particular site could not be --
5 claims could not be processed from that -- from that
6 site through the complex-wide approach. They typically
7 would expect to have a fairly limited scope of AWE
8 work, not a site that did -- cranked out tons and tons
9 of uranium years after years after year. And so it --
10 the complex-wide AWE approach takes some very
11 conservative, in our terminology -- in other words,
12 very high potential exposures and essentially says even
13 under these conditions for this certain set of cancers,
14 it looks like these -- these claims won't be
15 compensable even under these worst-case conditions and
16 therefore it allows some processing of some AWE sites
17 claims.

18 For the complex-wide -- the complex-wide process is what we
19 refer to as an efficiency process which follows from
20 the regulations statement that dose reconstructions
21 done under worst-case assumptions, and if you do a dose
22 reconstruction under worst-case assumptions and it's

1 clear that the probability of causation would exceed 50
2 percent, then in those cases you have -- those cases
3 can be considered complete. No additional research
4 will change the probability of causation determination
5 -- or if additional research would only cause the
6 probability of causation to go lower -- and therefore
7 there is no need to pursue and research in greater
8 depth this particular dose reconstruction. So with
9 that in mind, there are -- there is a population of
10 claims that it would appear would fall into the
11 category where certain worst-case assumptions can be
12 made. And even if those worst-case assumptions turned
13 out to be true, which in many cases they seem almost
14 incredible, that even if they were true that this --
15 this -- the probability of causation on this case -- on
16 this claim will not rise to the 50 percent level and
17 therefore these worst-case assumptions can be used in
18 application to these various claims in order to
19 complete the dose reconstructions and provide answers
20 to claimants who have been waiting quite some time for
21 their answer to their compensation claim.

22 So that was a brief discussion of the purpose of the

1 complex-wide AWE -- or complex-wide DOE technical basis
2 approach. And it's structured in four documents that
3 are called Technical Information Bulletins. They
4 address the four major types of exposure that you would
5 find in a site profile. The ones that would not be
6 described are facility and processes, which is one of
7 the five -- five topics in a full site profile, and
8 then the introductory section, which is the sixth
9 section of a site profile.

10 So these are the documents that comprise it. These are the
11 first two about internal dose estimates; external dose
12 estimates -- you'll notice this is for
13 thermoluminescent dosimeters; occupationally-related
14 diagnostic X-rays; and occupational doses from elevated
15 ambient levels of external radiation, which we
16 oftentimes call environmental or occupational
17 environmental dose.

18 So describing briefly the approaches that are followed on
19 this -- in this particular regimen for dose
20 reconstruction, first there is a case selection
21 criteria that you limit the applicability of this,
22 first of all, to more recent employment. It wouldn't

1 be appropriate to use a complex-wide overestimates
2 because we've made certain assumptions about -- in our
3 process here that would apply to more recent times, say
4 from 1970 or 1980 forward, but would not necessarily
5 apply to very early work. So the applicability of the
6 complex-wide regimen is really limited to more recent
7 employment.

8 We apply maximizing factors to recorded doses and missed
9 doses in order to provide confidence that we really
10 have captured the worst case that this person may have
11 been exposed to. Use a maximum credible undetected
12 intake or a implausible undiscovered intake, depending
13 upon the terminology you want to use, to evaluate a
14 worst-case assumption for an internal dose. And then
15 we choose parameters that maximize POC both by
16 maximizing the dose and by the selection of the
17 radiation types and photon energy types.

18 (Pause)

19 Okay, so for a little more information about the approaches
20 that are taken here in terms of the maximizing doses
21 and maximizing probability of causations, I made a few
22 notes to go through the various approaches to kind of

1 describe what was done in the various Technical
2 Information Bulletins to describe these -- this
3 maximizing approach.

4 For the internal dose assessment component, first of all,
5 the employment has to be from a DOE site or a national
6 laboratory that had an established radiation control
7 program. It certainly wouldn't be appropriate to do
8 this with -- this approach with an AWE site which had a
9 much more limited radiation protection program because
10 there's certain assumptions about what could or
11 couldn't be seen at the time of employment. So the
12 hire date for all these claims must be 1970 or later,
13 and for some applications at some sites, 1970 is also a
14 little early and so those cases can only start if the
15 employment -- dose can only be done under this regimen
16 if the employment started later than that.

17 For internal dose assessment, the claims must involve a
18 cancer of an organ or a tissue that does not
19 concentrate the radioactive materials that the person
20 might have been exposed to. The cancer causation or
21 the dose to an organ from internal exposure depends
22 quite a lot on whether that organ concentrates the

1 radioactive material or not, and if it doesn't, the
2 internal doses tend to be relatively minor compared to
3 organs where it does -- where the material does
4 concentrate. So this approach can only be used for
5 those organs that don't concentrate the radioactive
6 material.

7 The claims should involve people who either weren't
8 monitored for internal exposure or who were monitored
9 for internal exposure and had no positive bioassay
10 result. And they should be for people whose jobs
11 appear to be -- have an unlikely potential for
12 significant internal exposure. So we're selecting a
13 certain population of claims where we're liable to have
14 low external -- low internal exposures -- internal
15 exposures.

16 Okay, the maximum or the -- the implausible undiscovered
17 intake is based on the control concept of maximum
18 permissible body burden, which Mr. Andrade referred to
19 earlier, because that's the way the standards were
20 written in the 70's and 80's, and it essentially -- the
21 worst case assumption for the internal exposure is that
22 the energy employee was exposed to a -- an intake that

1 would cause a significant fraction of the maximum
2 permissible body burden for an entire list of
3 radionuclides on his first day of employment during his
4 first year of employment, and that based upon the
5 selection of the case, that this had to be from a case
6 with a radiation protection program. Our belief is
7 that the radiation protection program would not miss
8 that sort of an intake, so the maximum credible intake
9 is developed in that way. It is -- the most soluble
10 form of the radionuclide is chosen for the dose
11 reconstruction because that will provide the highest
12 dose for these non-metabolic or non-concentrating
13 organs. And the actual intake is several-fold times
14 the maximum permissible body burden that was in use at
15 the time because of the rapid clearance from the short-
16 lived components -- or short-lived compartments in the
17 model.

18 There are actually two lists of radionuclides that are used
19 in this postulated intake. One is for sites with
20 reactors and one is for sites without reactors. In
21 addition, for uranium sites the ten percent maximum
22 permissible body burden provided really fairly low

1 chronic exposure could -- over an employment period
2 could achieve ten percent of maximum permissible body
3 burden, which interestingly enough doesn't seem to be
4 the case in very many of the other radionuclides, so
5 the uranium number was sort of artificially inflated,
6 so the postulated uranium intake is quite a lot larger
7 than -- than it would be based on the original
8 calculation method in order to demonstrate that this
9 would be quite a large chronic exposure over a long
10 period of time, and it would still have to have been
11 missed by this radiation protection program. So those
12 are the key features of the internal dose assessment
13 approach.

14 The elevated ambient level of external radiation approach or
15 the environmental occupational dose approach is based
16 on a review of environmental monitoring reports, as
17 well as some of the site-specific research that's going
18 into the preparation of the site-specific Technical
19 Basis Documents. And what we can find from the review
20 of the environmental monitoring reports is from 1980
21 on, environmental releases were just not really all
22 that big that they would be causing measured --

1 measurable radiation exposures to a radiation
2 monitoring device. From 1970 and 1980 in certain cases
3 at certain sites, from our research, it appears to be
4 the same, as well. And another aspect of this -- this
5 particular component of dose is it's appropriate to add
6 this dose to a dose reconstruction only when this dose
7 is not measured by the person's personal monitoring
8 program. So the person is wearing his dosimetry device
9 and is exposed to this ambient elevated radiation level
10 while he's at work, his dosimetry device will record
11 that dose. The only reason -- and so it would be in
12 his dose record, unless there was a control dosimeter
13 that was used for a background subtraction that was
14 located in a similar area. So if the control dosimeter
15 was irradiated to this elevated level, as well, and if
16 in fact the site was using that control dosimeter as a
17 background subtraction on their personnel dosimeter,
18 then that excess ambient dose would be subtracted off.

19 And so from our research we found certainly at some of
20 the bigger sites where we're further along in our
21 research that the releases were getting quite small in
22 the 70's and the dosimetry practices were such that

1 those -- that inappropriate control subtraction --
2 background subtraction was in place. And so we should
3 be able to identify additional time frames in the 70's
4 to use these -- we think for most of the 70's,
5 probably.

6 The medical occupational exposure was established based upon
7 an evaluation of literature searches of exposure
8 techniques and resulting exposures. Over history
9 various studies were done at various times. The
10 numbers -- there's a particular table of numbers that
11 are used for organ doses like -- that would likely
12 result from exposures before 1970, another table for
13 1970 to 1985 and then another table from 1985 forward.

14 These generally reflect the improvement in the
15 understanding of the role of filtration, columnation*
16 and technique factors and the general improvement that
17 can be seen in these various scientific reports that
18 were written over time to describe medical dose re-- or
19 the medical exposures.

20 Since the remainder of these types of radiation exposure can
21 really only go from 1970 and forward, the pre-1970
22 number in this document won't be used in this complex-

1 wide, but they may be used to facilitate the
2 preparation of other medical profile information later
3 on when we can't find specific information on a given
4 site going back before 1970.

5 Finally, for the external exposures, we again have case
6 selection of cases where the radiation exposure appears
7 to be relatively low and the cancer is in a location
8 that is not -- does not have a particularly high risk
9 factor associated with radiation exposure. So we go in
10 by selecting cases that look as if they have a low
11 chance for exceeding the 50 percent probability
12 threshold, select those cases and the external
13 dosimetry must be done by thermoluminescent dosimetry
14 rather than film. And the person's -- should have no
15 neutron exposures. He should either be unmonitored for
16 neutron exposure or he should not have a measured
17 neutron exposure, and he should have a job that would
18 make it look like he probably wasn't exposed to
19 neutrons except maybe incidentally on occasion, but no
20 appreciable neutron exposure.

21 So in this approach we apply an overestimating conversion
22 factor to -- and the purpose of that is to provide an

1 upper bound for the uncertainties associated with some
2 of the things that were going on in dosimetry
3 technology. For instance, dosimeters respond to
4 different kinds of radiations and different kinds of
5 energies in different fashions. Calibration methods
6 sometimes varied from (Inaudible) calibrations to
7 (Inaudible) calibrations. Workplace radiation fields
8 could be mixed, fields -- not nice clean AP fields like
9 you see in the work -- in calibration facility, and
10 various facilities might have different administrative
11 practices for when you record a dose and when you write
12 down a zero and things like that.

13 So the overestimating correction factor is developed from
14 really two -- two major components. One is a combined
15 uncertainty associated with geometry and calibration,
16 uncertainties associated with measurement at the time.

17 And an upper bound on the uncertainty that was
18 probably being experienced by these sites that were
19 monitoring with TLDs in the 1970's and early 80's. And
20 that's a pretty -- that's established in the Technical
21 Information Bulletin as being about a number of 1.8,
22 and then there's a maximum organ dose correction factor

1 to convert this -- this dose number, the recorded dose
2 number as adjusted to the dose to the organ in
3 question, and that's just universally chosen with this
4 -- with this approach to be a maximizing 1.1, which is
5 actually higher than any of the DCS for this type of
6 radiation and this -- this dose conversion factor. So
7 those two maximizing values, when they're combined
8 together, give a -- conveniently give a number of about
9 two, so the consistent or overestimating correction
10 factor is a factor of two applied to the recorded dose
11 from these various sites for these selected cases in
12 order to compensate for the uncertainties that may be
13 there, provide an upper bound for what their exposure
14 may truly have been. And then from missed dose
15 standpoint, since the person quite likely wore some
16 dosimeters that read zero, the missed dose concept or
17 missed dose approach on this maximizing approach is
18 just to generate a missed dose as if you wore 12
19 dosimeters in a year and the limit of detection was 30
20 and they were all zeroes, and then the -- and apply
21 that dose correction factor again, as well, so double
22 that number as well to arrive at a -- a missed dose for

1 these approaches. And the -- this is then applied in a
2 -- in the lognormal distribution technique that's
3 described in our implementation guide, the limit of
4 detection divided by two times N as the geometric mean
5 of a lognormal standard deviation.

6 So those were some of the more -- some of the more graphic
7 details or bloody details of the approach that was
8 using -- that we're using on this complex-wide
9 approach. Again, this is for a -- for a limited set of
10 claims, and it's to facilitate our ability to provide
11 more timely answers to claimants who have filed a claim
12 and they deserve an answer to their claim.

13 We also recognize that much of the profile work so far has
14 been done from a particular point of view, not so much
15 from the affected employee point of view, so the -- at
16 the -- this was pointed out at the St. Louis meeting,
17 and so we are engaged in processes to identify
18 populations of workers, whether they be labor --
19 represented by labor unions or whether they be other
20 affected workers, to provide input to us in the
21 preparation of Technical Basis Documents or for
22 documents that are nearing completion; after completion

1 of the Technical Basis Documents, to provide any
2 comments on what was prepared to see if we need to
3 provide additional information, modify what was placed
4 there.

5 I mentioned earlier that there was a meeting held in
6 November at Savannah River. We also have one scheduled
7 for Hanford in January. We've established a docket on
8 our web page for each of the Technical Basis Documents
9 so that any comments made on that Technical Basis
10 Document will be viewable there just as easily as the
11 Technical Basis Document is viewable. And then we are
12 looking into other information-gathering approaches.

13 We have an obligation to provide a plan for providing worker
14 input into Technical Basis Documents, following the
15 Board's recommendation at the last meeting, and while
16 we've not finalized that plan, some of the components
17 of the plan will follow along these bullets that I have
18 here on the -- on the screen.

19 I'll be glad to entertain any questions or comments.

20 **DR. ZIEMER:** Thank you, Stu. Let me ask if you or one of
21 the staff can tell us what the response was to the
22 November 11th meeting at Savannah River in terms of

1 input from people on the site.

2 **MR. HINNEFELD:** Well, I only know what Jim -- I only know
3 what Jim told me. Jim has heard a couple comments that
4 it was very well-done and thanks for coming and gee, we
5 really are glad to hear that. And then there have been
6 other comments made in other avenue -- agendas that
7 really wasn't what we needed, that wasn't what was
8 intended. So I don't know whether different attendees
9 came away with different views or how that came about,
10 but Jim certainly did at the -- at -- my understanding
11 is at the meeting itself, at the end of the meeting,
12 the participants who spoke were appreciative and
13 thought that it had been -- been done pretty well.

14 **DR. ZIEMER:** You have some idea of what the level of turnout
15 was for that meeting?

16 **MR. HINNEFELD:** Well, that was not a public meeting. It was
17 a meeting with labor --

18 **DR. ZIEMER:** Oh --

19 **MR. HINNEFELD:** -- certain labor officials --

20 **DR. ZIEMER:** -- okay, gotcha. Gotcha.

21 **MR. HINNEFELD:** -- and there were eight or ten, I think,
22 something like that.

1 DR. ZIEMER: Individuals that had been identified as contact
2 points --

3 MR. HINNEFELD: Yes, yes.

4 DR. ZIEMER: Thank you.

5 MR. HINNEFELD: Yes.

6 DR. ZIEMER: Jim?

7 DR. MELIUS: Yeah. I think actually someone -- one of the
8 labor officials that was at that meeting will be
9 speaking in the public comment period, so we may get
10 some additional feedback on that -- on that meeting --
11 time.

12 I would like to thank Larry and staff for going forward with
13 a plan, and I understand that it's being worked out
14 still. But appreciate making the effort and setting up
15 these meetings 'cause I think they will be -- be
16 helpful and I would hope they'd also include some way
17 which is admittedly more difficult to deal with some of
18 these -- particularly the AWE sites where sort of the
19 workplace is closed or dispersed and how do you reach
20 out to -- to people, but some sort of a briefing for
21 claimants or something I think might be -- be helpful
22 for -- so people understand what's going on with this

1 process.

2 I've got a number of questions, but -- and some of these may
3 be more appropriately dealt with later on in our
4 meeting, but I think the entire Advisory Board did
5 receive an e-mail from a person regarding a conflict of
6 interest issue on these site profiles at the Rocky
7 Flats site profile, and I don't know -- you want to
8 take that up later or what the plan --

9 **DR. ZIEMER:** I received an e-mail myself a day or two ago.
10 I don't always check my e-mail every day, but I think I
11 got it Friday. I think it came from -- perhaps from
12 Terry Berry --

13 **DR. MELIUS:** Yeah, last Thursday is when I -- date off of
14 mine.

15 **DR. ZIEMER:** -- relating or raising an issue that I think is
16 what you're referring to. And perhaps -- I don't know
17 if this is the time to look at that, but perhaps that
18 can be addressed at -- that as a starting point by
19 staff. Have you -- you've seen either the -- perhaps
20 the staff has not seen the e-mail, but has had some I
21 think contact on that issue, have you not?

22 **MR. ELLIOTT:** Yes.

1 DR. ZIEMER: And you want to address that now?

2 MR. ELLIOTT: Yes.

3 DR. ZIEMER: And maybe explain for everyone what the issue
4 is and how it's been addressed.

5 MR. ELLIOTT: Yes, Ms. Berry wrote me an e-mail before she
6 sent the one to the Board. I have not seen the one she
7 delivered to the Board yet. But the issue essentially
8 is is that an individual on the ORAU team who is
9 working on the site profile for Rocky Flats, prior to
10 the genesis of this whole program, evidently provided
11 some testimony in a litigation on her husband's claim
12 and so we're aware now of this. It's actually -- we
13 became aware of it once we had the disclosure up on the
14 web site that this particular individual from ORAU had
15 performed in this regard. So we at the Department are
16 now looking into this and evaluating what needs to be
17 done in this regard.

18 We do take this very seriously and we had another instance
19 in -- last meeting in Cincinnati -- or in St. Louis
20 where we had a -- another situation called to our
21 attention which was slightly different in that a claim
22 undergoing appeal process or in the courts, at least,

1 was -- there was some testimony being provided against
2 the claimant from a principal of one of the firms that
3 our ORAU team subcontracts with, and that particular
4 individual was not serving on any site profile
5 development or dose reconstruction. But we have worked
6 with the ORAU team and that particular subcontractor is
7 being -- will be released. They will no longer be
8 working on our site profiles or dose reconstruction
9 processes.

10 So that addresses both of those that have been brought to
11 our attention. We're still working on this latest one
12 and how we're going to deal with that.

13 **DR. ZIEMER:** Thank you very much. Jim, did you have a
14 follow-up?

15 **DR. MELIUS:** I have a number of questions, but just as a
16 follow-up to that particular point, I would just hope
17 as you're dealing with these issues that you're also
18 trying to evaluate other sub -- subcontractors, I guess
19 they would be called, that might have similar problems
20 so that there's some sort of a policy or something
21 being developed so we don't have to sort of constantly
22 deal with the individual situations. I know it's

1 difficult and hard to -- to know when you're somewhat,
2 you know, dependent on what information is provided to
3 you or provided to ORAU and then on to you, but I mean
4 some sort of over -- communication of other
5 subcontractors or something to just make sure that this
6 -- try to avoid this as much as possible I think would
7 be helpful.

8 **MR. ELLIOTT:** Absolutely, that is part of the review that's
9 underway right now and discussions that are being held
10 and what type of contract language do we need to have
11 in place.

12 **DR. MELIUS:** Yeah. Yeah. My next question is also sort of
13 procedural, but on Friday I received a FAX of a letter
14 to you, Paul, from Congressman -- Congressman Quinn,
15 Congresswoman Slaughter and Congressman Reynolds from
16 western New York regarding -- or asking the Board to do
17 -- review the site profile for the Bethelhem Steel
18 site and for raising a number of particular questions
19 to -- to address. And this may be more appropriate for
20 us to take up tomorrow, but I just didn't know if
21 everybody else was aware of it on the Board or if we'd
22 received this or --

1 **DR. ZIEMER:** I don't know the answer to that. I just myself
2 got a copy of that before I left for the meeting here,
3 actually studied it on the -- on the plane and I need
4 to discuss that I think also with the Department and
5 review the related issues to how that particular letter
6 might be handled. But I have no knowledge of whether
7 other Board members received copies of that letter.

8 **DR. MELIUS:** Okay. Could we make copies then for everybody
9 on the Board?

10 **DR. ZIEMER:** Well, I'll make --

11 **DR. MELIUS:** Yeah.

12 **DR. ZIEMER:** -- a copy available to Cori and make sure the
13 Board has copies of that, that --

14 **DR. MELIUS:** I've got that with me, so --

15 **DR. ZIEMER:** Thank you.

16 **DR. MELIUS:** -- that's fine. I just didn't know what
17 happened with that.

18 The issue on these site profiles that we were just briefed
19 on, I'm a little -- still a little bit puzzled, I
20 guess, as -- or unsure of exactly what the process is
21 now. Will we -- we go back a few years when we first
22 started the advisory committee and we're doing the

1 original set of regulations and briefings and so forth
2 -- presented sort of where NIOSH was at that point in
3 time with this program of doing dose reconstructions.
4 We had a number of sort of technical documents that
5 were being developed. And then we -- you moved along
6 and really got the program going, now we've gone --
7 we've sort of changed that original approach. We have
8 the site profile process which originally was -- at
9 least as I remember it, was going to be at the end of
10 the process. You'd compile that from individual dose
11 reconstructions. And now that -- now we're doing it up
12 front and using it as a -- you've described it as a
13 handbook for the people doing the dose reconstructions.

14 And it would certainly be helpful for me and maybe
15 other Board members -- I'd be curious how others feel --
16 -- to understand a little bit how your -- how you're
17 using these as a handbook, maybe taking Savannah River
18 or one of the other completed ones and as you've gone
19 through a number of individual dose reconstructions
20 using that, providing with -- us with a briefing at the
21 next meeting on how you are, you know, using that with
22 some examples and so forth. I think --

1 **MR. ELLIOTT:** Okay.

2 **DR. MELIUS:** I think the last time Jim talked about this,
3 you really hadn't completed enough to do these --
4 particularly for the more complicated sites, like
5 Savannah River. I think for Bethlehem Steel and some
6 of those, it's more -- more straightforward, but for
7 Savannah River and the other sites, it's a -- more
8 complicated and it certainly would help me to
9 understand what you're doing and for us as part of our
10 review of the program to see how you're doing that, I
11 think it would be useful to do.

12 And secondarily, as part of that, as I recall, when we
13 originally talked about dose reconstructions and yeah,
14 you were going to be developing policies over time, I
15 guess I would see some of these -- both the site
16 profiles, but also these DOE-wide -- industry-wide
17 documents, your guidance doc-- you're developing as
18 being sort of Technical Basis Documents that are part
19 of this process that we'd expect to be developed as you
20 go along. And when we originally started, we talked
21 about the Board reviewing these or sort of having a
22 review process. And I think we as a Board sort of have

1 to decide -- and you at NIOSH, have to decide how we're
2 going to do this. Some of the early documents got peer
3 review, outside technical peer review. Are we now
4 relying on our -- our contractor to do the technical
5 review on these or is the Board supposed to be doing
6 the review of these, approving these? You know, sort
7 of what is the process going to be? I think, you know,
8 your briefing today is helpful and I appreciate it, but
9 it's not really us reviewing these and --

10 **DR. ZIEMER:** Right.

11 **DR. MELIUS:** -- in detail and don't pretend to, and I think
12 we sort of have to come to grips with how that's going
13 to go forward 'cause we have a lot of -- lot of your
14 work that figure -- lot -- what you're doing that we
15 just sort of -- we're blinded to. We -- we haven't had
16 time -- and understandably. I mean you've been, you
17 know, trying to get things done, so I don't think it's
18 anybody's sort of fault or placing blame, but I do
19 think that we as a Board have to sort of look at how
20 we're reviewing -- and particularly as we come into
21 doing individual dose reconstruction reviews, we don't
22 want to be in the position of, at a later point in

1 time, saying well, gee, this -- this particular overall
2 technical document was wrong or led to serious
3 problems. Now I'm not saying that's going to happen,
4 but I do think we have to talk about that and come up
5 with some way of -- systematic way of approaching this
6 and some of that's I think a better understanding from
7 you. And maybe not at this meeting, but maybe at this
8 next meeting of sort of what -- what are the documents
9 you see being developed, what's changed, what's -- what
10 kind of documents are -- are sort of just procedural,
11 what requires sort of a technical review, then how do
12 we get that technical review done?

13 **DR. ZIEMER:** Let me ask for other Board members to also
14 maybe weigh in on those comments. While you're
15 thinking about your responses, let me also point out
16 that one of the things that's included in -- at least
17 at the front end of our audit process is to ask our
18 contractor, as they do the various types of audits of
19 dose reconstructions, is in a sense a kind of audit of
20 the usefulness of the site profiles insofar as those
21 assist in the dose reconstruction. So we do -- or I
22 think we're looking toward having in place something

1 that will help us do a kind of evaluation because I
2 think the process, if it works properly, should point
3 out to us strengths or weaknesses on site profiles,
4 either generically or individually, as the case may be.
5 I don't recall us -- well, in terms of our charter, we're
6 not required a priori to approve site profiles. On the
7 other hand, the Board itself may decide that it wants
8 to look at them in some fashion in the audit process as
9 site profiles, or address particular ones. But I don't
10 believe our charter calls for us, in advance, to
11 approve site profiles.

12 **DR. MELIUS:** Yeah, I think you're right, Paul. But I do
13 think -- well, our charter does call for review
14 individual dose reconstructions --

15 **DR. ZIEMER:** Right.

16 **DR. MELIUS:** -- to the extent --

17 **DR. ZIEMER:** Right.

18 **DR. MELIUS:** -- they're used there. We also, I think, when
19 we approved the original set of regulations that guided
20 the dose reconstruction process, we talked about the
21 Board advising NIOSH on technical issues --

22 **DR. ZIEMER:** Right.

1 DR. MELIUS: -- that would develop over time.

2 DR. ZIEMER: Right.

3 DR. MELIUS: Now some of these were technical changes to
4 what was originally approved, some of these would be
5 sort of further developments. And I just think we have
6 to sort of systematize in some way -- part of my
7 question comes from sort of what is the full scope
8 going to be of our dose reconstruction review contract
9 that's out there. Is it going to review every
10 procedure? Is it -- you know, do we select? Is it
11 every so -- site profile or -- or not, and I -- and
12 then we get Congressional letters asking --

13 DR. ZIEMER: Well --

14 DR. MELIUS: -- about that, too, and that makes --

15 DR. ZIEMER: -- keep in mind, too, that an audit process --
16 I have to keep stressing this, to myself and to the
17 Board and others -- that an audit process is not 100
18 percent review of everything that's done. In fact, our
19 audit process calls for us to review something like two
20 and a half percent of the dose reconstructions.

21 Now it's very true that many of those dose reconstructions
22 will have used the same site profile for at least part

1 of the process of reconstructing dose, so it's hard to
2 imagine that in some form or another we won't in fact
3 be able to evaluate those. But I'm not -- I'm not
4 speaking against systemizing this in some additional
5 way, but simply reminding us that we will in fact have
6 opportunity to address that.

7 I do appreciate learning about what you might call the site-
8 wise (sic) things because there are certain issues that
9 lend themselves to that kind of analysis. Some of
10 those things, whether they're sort of site-wide or more
11 localized, I think will always be subject to
12 interpretation of validity of assumptions. Let's take,
13 for example, the medical exposure of workers. You will
14 make assumptions I think based on practice as to what
15 film speeds are used, what beam filtrations are used,
16 what columnation is used -- all of which affect patient
17 dose to the organ being examined, as well as dose to
18 other organs from either scatter or a practice which in
19 early days was very common and that was to remove the
20 columnation because the lights were not aligned with
21 the true X-ray beam and the way you get -- solve that
22 easily is rather than get the X-ray machine fixed, you

1 just pull out the columnator*. And if your beam is
2 wide enough, you'll sure hit the organ you're
3 interested in, and every other organ, as well.
4 And I don't know that -- I guess, you know, what assumptions
5 are made? Do you make the worst -- a worst-case
6 assumption in that situation is that there's no
7 columnation.

8 **MR. HINNEFELD:** As a matter of fact, I think the early --
9 very earliest numbers -- table numbers in the medical
10 do make that assumption.

11 **DR. ZIEMER:** Okay. 'Cause it was a very common practice.
12 Okay. But those are the kind of issues that I -- I
13 think a sampling can help us have a level of confidence
14 that -- you know, we may not have to sample every
15 assumption made, but if you start sampling and it looks
16 like the right thing's being done, then that gives you
17 a level of confidence.

18 **MR. HINNEFELD:** Okay.

19 **DR. ZIEMER:** Other -- I don't mean to monopolize this.
20 Tony?

21 **DR. ANDRADE:** Yes, I'd like to just comment that, first of
22 all, we should also remind ourselves that we are not --

1 we're not an expert board. We are an advisory board,
2 so I'm not sure to what extent we should really look at
3 all of the technical details of even any one of these
4 site profiles.

5 Two is that I do recall that several meetings ago it was
6 announced that site profiles would be developed and
7 that they would be used in a very limited sense. And
8 as was presented today, you got a feeling for the
9 limitations that are imposed on their applicability.
10 For example, the age of the employee, the time during
11 which they were working, some of the assumptions made.

12 And I can just imagine the type of filtration or
13 efficiency that you're gaining from these for the types
14 of employees that probably would never achieve a POC of
15 50 percent. And we're talking about people that
16 perhaps handled the bioassay samples and took them back
17 and forth to the laboratory, administrative assistants
18 that worked nearby to say neutron-generating
19 operations, those sorts of employees in which doses
20 themselves were probably extremely, extremely low. So
21 given all those factors -- oh, and along with the fact
22 that we do have a task order out that is supposed to

1 direct a subcontractor to us to look at -- especially
2 site profiles on top of individual dose reconstruction,
3 I really feel that any further let's say work added to
4 the Board's schedule would at this point just be
5 relatively non-value added and that, insofar as this
6 Board member is concerned, I am quite satisfied with
7 the monthly or however often we meet updates like the
8 one that was just presented that gives me a feeling for
9 how these are being used, what sort of details are
10 going into them and the types of analyses and
11 assumptions being made within them. That's all.

12 **DR. ZIEMER:** Okay. Let's -- Mark and then Jim.

13 **MR. GRIFFON:** Yeah, I just -- I do agree with one part of
14 what -- when Tony said that we do have a task order
15 out, and the contractor's going to review the site
16 profiles, even though we're not -- and just a reminder
17 that the contractor's work is -- is the Board's work.
18 I mean the contractor's working for the Board, so we
19 are going to be reviewing site profiles, and I think
20 that's where we're going to get into the meat of it.

21 I do have a couple of comments about the presentation,
22 though, just -- some of which I've probably said

1 before. But I -- you know I still -- in your second
2 slide, I see things like limited scope, and I do
3 understand, you know, from your presentation what you
4 meant by that. But the fear I still have with some of
5 what I've seen so far is -- is the idea of -- there are
6 some sites where I think a better understanding of
7 operational details is going to give a very different
8 picture of potential worst-case doses. And if we just
9 skim the surface with a limited-scope site profile --
10 and I'm not saying -- I mean I know it's a lot of work
11 to do these things, too, but we could easily miss, you
12 know, some very -- some operations which have very
13 different exposures than the general building, for
14 instance, and I've found that in some of the work that
15 I've done. And it may not affect a lot of the workers
16 on the site, but it may turn out to be several of the
17 claimants. So you know, without going to that level of
18 detail, I fear that we may miss some of that and
19 underestimate worst-case doses for a certain fraction
20 of people. That's one thing.

21 The other question I -- this is more of a -- go as a
22 statement. The other question I had was later in the

1 presentation you talked about the missed dose with the
2 external exposures. I didn't really hear you address
3 unmonitored dose, and I know that's come up again and
4 again during public comments, we've heard it over the
5 years from DOE hearings and things like that. Some
6 employees report anecdotal reports that their badges
7 were tampered with, they weren't badged for certain
8 high level operations. How are -- how are you handling
9 potential unmonitored exposures or -- in your -- in
10 your...

11 **MR. HINNEFELD:** I guess on the face of it, without looking
12 at a specific instance of a specific case and a
13 specific set of claims, I would say that claims of that
14 nature would -- I guess might tend to make it more
15 difficult to apply a complex-wide standard approach.
16 And so it would fall into sort of the case selection
17 portion of what's going through this process. I mean
18 you kind of have to -- I don't know that I can say
19 universally, whoever says -- you know, makes that claim
20 that we want to run through that process, I don't -- I
21 won't stand here and make that claim, but I think it
22 would affect -- you know, those kinds of issues would

1 affect the case selection for what might go through
2 this.

3 **MR. GRIFFON:** Okay.

4 **DR. ZIEMER:** Jim.

5 **DR. MELIUS:** Yeah. Just in response to what Tony was
6 saying, I'm not -- what I was suggesting wasn't
7 necessarily to add to the work for the Advisory Board,
8 but in addition to the -- sort of the scientific
9 confidence that we have in what NIOSH is doing, I think
10 it's also our credibility issues and we have to
11 remember that at the end of the process when we've gone
12 through -- we're not going to be able to review
13 everything through our contractor -- that what we don't
14 review, the credibility of that has to be defended in
15 some way.

16 Now if we say we've reviewed -- we may be confident by, you
17 know, two percent or whatever it is of the cases,
18 individual dose reconstruction reviewed that, you know,
19 that's representative and that we've -- provides
20 credibility to the process. But to some extent we have
21 to think the same way about the site profiles, about
22 these other Technical Basis Documents and I was just

1 arguing for some sort of systematic approach and that -
2 - and also to make sure that NIOSH wasn't expecting us
3 to review -- to provide the technical review on all
4 these procedures, even though it may be useful from a -
5 - from NIOSH's point of view from -- in terms of the
6 credibility of the application of these -- these
7 processes, so -- I think it's just sort of coming to
8 grips with that.

9 **DR. ZIEMER:** Thank you. Tony, another comment?

10 **DR. ANDRADE:** Just a quick question for Mark. Do you have
11 any idea on the percentage of these -- of the work in
12 which we're -- in which our subcontractor's actually
13 going to be looking at site profiles?

14 **MR. GRIFFON:** I don't recall off-hand. I mean the last task
15 we laid out a pretty aggressive -- I forget the
16 numbers, but we have a fair -- fairly high percentage
17 of the overall site profiles. I think it was four AWES
18 and eight --

19 **DR. ZIEMER:** I don't remember the numbers, but in terms of
20 percent -- percent-wise, it's much higher than for
21 individual cases. But that's understandable in terms
22 of the fact that many -- most of the cases come from a

1 relatively small number of sites, actually.

2 **MR. GRIFFON:** Right.

3 **DR. ANDRADE:** Good. Thank you.

4 **DR. ZIEMER:** Other comments or questions? Okay, thank you
5 very much. Thank you, Stuart, for that update.

6 **IMBA UPDATE**

7 Now we're going to turn our attention to the internal dose
8 issues or the -- the calculation of internal dose. The
9 terminology is Integrated Modules for Bioassay
10 Analysis, and we're going to get an update on that from
11 David Allen of NIOSH. David.

12 **MR. ALLEN:** Okay. Can you hear me? All right. Thank you.

13 As Dr. Ziemer said, my name's Dave Allen. You've seen me
14 before. It's been a while, but you have seen me
15 before. And he mentioned I'm giving a presentation
16 today on IMBA. And IMBA is the computer software that
17 we've been using for internal dosimetry calculations.

18 As Dr. Ziemer already mentioned -- as Dr. Ziemer already
19 mentioned, that stands for Integrated Modules for
20 Bioassay Analysis. The difference between IMBA and the
21 bulk of the commercially-available software for
22 internal dosimetry right now is that IMBA uses the

1 current ICRP models. Any -- most of the other
2 commercially-available software uses ICRP-30 models,
3 which are a generation back.

4 I think it was easiest first to start with a little bit of
5 history on the IMBA program, and up until the early
6 90's, ICRP-30 was the current ICRP models for internal
7 dosimetry. In 1994 ICRP published a new lung model for
8 internal dosimetry, and that was the beginning of
9 various new models, including biokinetic models. As --
10 this particular lung model was considerably more
11 complicated than the last, and as such, while they were
12 producing this model, they also produced some computer
13 programs to help evaluate that model. Once the model
14 was published in 1994, the people that put that
15 computer program together, NRPB, went ahead and
16 packaged it as a software -- they connected --

17 **DR. ZIEMER:** Identify for everyone -- I -- I'm assuming, but
18 it's probably not true, that ICRP is known, but maybe
19 you should identify all the acronyms as you go.

20 **MR. ALLEN:** Okay, there's a lot of them.

21 **DR. ZIEMER:** If you remember them all.

22 **MR. ALLEN:** ICRP is the International Commission on

1 Radiological Protection. It's basically the worldwide
2 expert on internal dosimetry, recognized expert on
3 internal dosimetry, as well -- radiological protection
4 in general.

5 NRPB is the National Radiological Protection Board, which is
6 I think semi-private/semi-government agency of Great
7 Britain. Some of the people in that organization were
8 involved when the ICRP committee for developing that
9 lung model, and they developed computer software to
10 evaluate that while it was being produced.

11 Once the lung model was produced, they connected it to the
12 ICRP-30 biokinetic models, which were all they had at
13 the time, and packaged that software in a form known as
14 LUDEP. LUDEP then is like a hybrid of two different --
15 your current model/old model type of thing. It was a
16 DOS-based program. It was kind of clunky to run, but
17 it was something that you had.

18 Shortly after the lung model, ICRP then began producing new
19 biokinetic models, and as part of that, these
20 individuals at NRPB were also involved with that. And
21 as new models came out, they produced new computational
22 models or modules that would do those calculations.

1 And eventually all this was put together -- all these
2 individual computational modules were put together into
3 a -- one computer program, and that was known as IMBA,
4 hence the Integrated part of the acronym -- Integrated
5 Modules.

6 The first version of IMBA that I know of was IMBA-URAN, and
7 after they -- NRPB copyrighted this -- these
8 computational modules, they began putting IMBA together
9 in an integrated fashion. IMBA-URAN, they were
10 contracted to put together something a little more
11 user-friendly for the CANDU reactors. That ended up
12 doing only uranium, was all that would do. It was
13 pretty limited in scope, but it did put everything
14 together.

15 After that, near the same time, DOE contracted -- contracted
16 them to put together an IMBA EXPERT version, which
17 included more isotopes and a little more versatility --
18 quite a bit more versatility. That took some time for
19 them to complete, and then during that process, we
20 contracted them to put together an IMBA-NIOSH version.

21 That allowed for annual doses for a limited number of
22 isotopes, and gave us what we needed for this program

1 on a limited basis. Once the IMBA EXPERT was done for
2 DOE, we then asked for a modification of the software
3 which included all the functionality of the IMBA EXPERT
4 version, all those isotopes plus some additional
5 isotopes, and that was all put together into what is
6 now known as the IMBA EXPERT OCAS-edition.

7 Some of the features of the IMBA EXPERT edition is -- we can
8 do up to ten individual intake regimes. By intake
9 regime, that's -- that's a term given in IMBA, but it
10 essentially is specifying the dates; the route of
11 entry, whether inhalation, injection, et cetera; and
12 also whether it's a chronic versus acute. That all
13 together is one intake regime. You can specify up to
14 ten intake regimes, so you can give somebody an acute
15 intake on one day, followed by a chronic intake during
16 another period of time, followed by an acute ingestion
17 some other time, put it all together in one shot. So
18 it's good to have a number of those when you're talking
19 about a career dose.

20 As I already mentioned, it can do inhalation, injection and
21 ingestion. It can do -- whether -- it can do a chronic
22 versus acute on any of those intake routes. The

1 solubility parameters can be specified as ICRP default
2 solubility types, or you can specify individual
3 parameters if you know more about the material the
4 person inhaled or ingested.

5 Bioassay is -- we can use whole body counts, we can use lung
6 counts, urinalysis or fecal sampling. There's also a
7 few other bioassay types for specific isotopes, such as
8 we can use thyroid counts for iodine exposures if -- if
9 we have that data, we can use that then to determine
10 intakes.

11 IMBA can be used to calculate the intake from that bioassay
12 samples. It can be used to calculate dose from a given
13 intake or the calculated intake. The dose can be
14 effective dose, which is essentially a whole body dose,
15 or it can calculate tissue dose -- tissue or organ.
16 The dose that it calculates can be specified either 50-
17 year committed or, more important for us, they can be
18 specified as annual doses.

19 I'm going to take you through screen shots of the program.

20 This -- there's not a good way to do this presentation.

21 I'm going to take you through some screen shots just
22 because I think it will be a little quicker than

1 letting you watch a computer program work while it's
2 trying to work on the screen.

3 There's a number of pop-up screens and menus in IMBA. It's
4 -- gets to be a fairly complicated program, but the
5 three primary screens are the -- what I call the main
6 screen. That's the screen you get when you first turn
7 it on. The other two main screens are -- or primary
8 screens are the dose calculation screen and the
9 bioassay screen.

10 That's the main screen. When you first turn the program on,
11 that's what you see. For the most part, this is
12 somewhat administrative data for the intake. It will -
13 - over in this side here -- it's divided into somewhat
14 four sections. Starting over here, you're allowed to
15 specify the particular radioisotopes you're interested
16 in, and you can specify the exact intake if that's
17 where you want to start. If you want to start from
18 bioassay and calculate intake, obviously you leave that
19 blank and that would come about later. The bottom
20 section here is simply two buttons to take you to the
21 other two primary screens.

22 And the top section right here, I have a little blow-up of -

1 - a little clearer -- and as I said, this is somewhat
2 administrative detail for the intake, all the
3 information you need to put in ahead of time to start
4 off with. Off to this side, you have -- you can
5 specify the units you want the dose in, whether you
6 want to work in sieverts, rem, et cetera. You can
7 specify the units you want the activity to be in,
8 whether becquerels, dpm, that sort of thing.
9 And up here is time. You can specify whether you want to
10 deal with dates or whether you want to deal with time
11 since the intake, such as ten days, 100 days, et
12 cetera. In general, when you're dealing with an
13 individual's individual case, the dates are usually the
14 best thing to use. If you're dealing with a
15 programmatic issue, like you want to come up with an
16 excretion curve, then the days are probably better, the
17 time.
18 This date you see here is nothing more than a reference
19 date. If you're going to use time and specify the time
20 since a particular date, then that reference date'll be
21 the main thing. In the case over here, you see a zero
22 in that time box. That means in this case it's -- this

1 one represents 1/1/1980. If I were to put a ten in
2 there, it would represent 1/11/1980, that sort of
3 thing. And the reason for the reference date instead
4 of just time since intake is 'cause you can do more
5 than one intake. Some of these intakes could be years
6 apart, so you -- the program needs one reference date
7 to work with.

8 I mentioned on the other side you could do up to ten intake
9 regimes. That's specified in this area. As you add
10 more intake regimes to it, you get more tabs right
11 here. Each of these tabs, once you click on them, you
12 get an identical screen below here, and on this screen
13 you can specify the route; you can specify the mode,
14 whether it's acute or chronic; and you can specify the
15 start date. If you click -- if you click on the
16 chronic button, you also get another box to show up
17 there to -- for the end date. As I said, somewhat
18 administrative detail, but that's the -- the important
19 detail, of course.

20 **DR. ZIEMER:** Where does the solubility -- does that show up
21 later?

22 **MR. ALLEN:** Yes.

1 **DR. ZIEMER:** Okay.

2 **MR. ALLEN:** In fact, back to the main screen, the last
3 section is down here where it says model parameters.
4 There's a number of model parameters, and some of those
5 will appear or disappear depending on the route of
6 entry that you specified. Each of those allows you to
7 change the parameters associated with that type of --
8 those parameters.

9 I'm going to give you one screen shot -- that's the blow-up
10 of the solubility. When you click on one of those
11 buttons at the bottom of the main screen, you get a
12 pop-up screen. In this case I clicked on absorption.
13 I get this screen. It shows you a pictorial
14 representation of the model, as far as the solubility
15 part of it goes. It shows you the actual values that
16 are going to be used, and it also has buttons to allow
17 you to pick the default solubility types in this case -
18 - you know, F, M or S. You could also click on user-
19 defined and then put in your own values here.

20 **DR. ZIEMER:** What about particle sizes for inhalation, is
21 that --

22 **MR. ALLEN:** That is one of those other many buttons on the

1 model parameters, and I don't have a screen shot of
2 that. I didn't want to come up with all of them. And
3 that again is either default -- all the other models
4 have ICRP default or user-input, user-specified. You
5 can see on this screen you also get an F1 value, which
6 it could be specified on yet another screen, too.
7 They're linked. And the help button will actually give
8 you what the F1 values are for that particular isotope
9 you've already selected to get to this point, and it'll
10 tell you the chemical compounds associated with that --
11 what that's -- the default solubility type are for that
12 chemical compound, what the F1 value is for that
13 default solubility type and the ICRP reference where
14 that value came from. And you can simply click on that
15 help menu, click OK and it'll put the value in there
16 for you.

17 Okay. That was the main screen, and as I mentioned, there's
18 two more primary screens associated with the program.
19 It's somewhat backwards to do the dose one first, but
20 it's the easiest one to deal with and then I'll get
21 into the bioassay one.

22 When you click the dose button at the bottom of the main

1 screen, you'll come up with the dose calculation
2 screen. From this screen, you can start off by seeing
3 off to the side -- it'll tell you the quantity -- the
4 intake of -- the individual intake regimes that you're
5 about to calculate dose for. In this case I've got
6 three in there, and I think two of them are zeroes, so
7 it's probably a bad screen shot to put up there, but
8 that's what I ended up putting up.

9 Over here you simply have a calculate button. Once you hit
10 calculate, this will give you the effective dose from
11 this -- these intakes that you have specified -- these
12 ones that are listed over here. It'll also give you
13 the organ dose for each intake regime, as well as the
14 total of all three. And this screen you can see --
15 there's a slide bar. There's a lot more organs than
16 there's -- you can see from this screen, but...

17 These that you're seeing here, the effective dose and the
18 organ doses, are all 50-year committed doses. For
19 purposes of our program, that's not very useful. We
20 don't use that much, but it is there and it's a great
21 QA for the program itself to verify it against the ICRP
22 values.

1 Up here in the corner you see a button that says calendar.

2 What that button allows you to do then is get to where
3 you can calculate the annual doses. You get another
4 pop-up screen.

5 This is the annual dose calculation screen, and what it
6 allows you to do is input the start year. There's a
7 pick list of 30-some organs that you can choose from.
8 There is the end date, which would be the date of
9 diagnosis for us. And once you have all that
10 information entered in, you hit start calculate. It
11 takes a little bit of time, but it'll run through the
12 calculation and it'll give you the annual dose each
13 year from the start year to the diagnosis date. And
14 you can see from the screen, the last year it's going
15 to be a partial year, from the beginning of that
16 calendar year to the date of diagnosis.

17 The last two buttons are down here. That allows this
18 information to be copied to the clipboard or to be
19 exported as an ASCII file, which makes it much easier
20 to use. You can simply copy it to the clipboard, paste
21 it into say Excel if you wanted to, and then you have
22 all the values you want to...

1 Okay, the last primary screen is the bioassay primary
2 screen, and right here are two tabs. These are keys to
3 the screen. What you can see on there right now it
4 says bioassay to intake, and that would allow you to
5 calculate an intake from the bioassay. If you click
6 the other button, the other tab here, it gives you a
7 little different information here. It allows you to
8 predict the bioassay measurements from a given intake.
9 Sounds like a subtle difference, but it's an important
10 difference.

11 In this case I have urine selected here. I'm on the
12 bioassay to intake screen. When I hit calculate, it's
13 going to take the data that I've put in there, the
14 measurement data that I've put in there, try to fit the
15 data the best it can to all the intake regimes that I
16 put up there as far as the intake dates, routes of
17 entry, all that. It'll try to fit that data the best
18 it can to that and come up with the intakes, the actual
19 quantity of -- that was the intake.

20 If I go this button here, I have to specify dates that I
21 want it to calculate or predict what the bioassay would
22 be. I click a calculate button on that screen. It

1 doesn't change the intakes at all. It simply
2 calculates what a bioassay would be from those given
3 intakes.

4 Over here on this side I have actually three identical
5 areas, though they don't look identical right now.
6 Each of these areas allows you to choose a bioassay
7 from a pick list -- bioassay types, such as urine,
8 fecal, et cetera. It allows you to have the table or
9 the graph, and each one is identical, so in this case
10 I've got the table data for urine and a graph for the
11 urine samples. I can see them at the same time. It
12 makes life a little easier when you're working around
13 with the data. If I also had lung count data, I could
14 put that up there, either the table or the graph. If I
15 had a number of things I could put all three graphs up
16 there, however I wanted to work it out.

17 Each of these screens have a little tool button. If you
18 click that, you get a more detailed screen or a bigger
19 -- full-page screen of those individual spots. That's
20 just a little blow-up of the exact same thing I just
21 showed you. I thought it might be a little easier to
22 see.

1 There's the full-screen view of the table data, and you can
2 see you have two different colors -- color codings.
3 The green is for the prediction. That's if you want to
4 go from the intake to the -- predict what the bioassay
5 would be. The input in this case would be the dates
6 that you're interested in. In the case of urine also,
7 the collection period.

8 The blue area is actual measured data. It would be a date
9 that somebody was sampled, the collection period and
10 the actual measured quantity. The data type, there's
11 actually three options here. You can specify whether
12 that's a real quantity, an actually measured quantity,
13 or if it's simply a less-than. The less-than LOD
14 stands for less than limit of detection.

15 The third quantity I don't have on there is simply excluded.
16 From time to time you might get an outlier that
17 doesn't seem to make any sense, and that would allow
18 the dosimetrist to select excluded for that dataset,
19 and at that point the program will ignore it. It'll
20 still plot it on the graph, but that's the only thing
21 it'll do with it, so if you can ignore what looks like
22 an outlier and then all of a sudden everything fits

1 real well with the models, then you've got a chance
2 that it's -- it really was an outlier.

3 The other two are semi-self-explanatory. They show you the
4 measurement error and the error distribution. Your
5 options there are normal or lognormal.

6 It's a little better blow-up of the graph. When you click
7 the tool button on a graph, then you get this blow-up.

8 I've cropped a little bit of it out so you can't
9 really see what's going on down there, but that is
10 essentially a lot of administrative type information --
11 what scale you want, format for data, how many decimal
12 places, that sort of thing. As far as the scale, what
13 you see here are the days since that reference date
14 back on the first page. Off to the side here is the
15 actual measured -- or the quantity that you're trying
16 to measure. In this case I think it was in picocuries
17 per day for urine samples, I believe it was.

18 The blue dots are the measured values, complete with the
19 error bars. The black line that you see here is the
20 fit that IMBA did to that -- that data, based on the
21 intake regimes that you gave it. The green -- I don't
22 know how well you can see that -- actually follows all

1 the way along this black line, and the green is the
2 predicted bioassay. The reason you see such a
3 difference here is the graphing function itself is not
4 that sophisticated, and it's simply connecting dot to
5 dot that the program has calculated. When you see
6 something like this with the black line and it's say
7 several weeks after initial intake, someone might be
8 thinking it should be higher and they could be coming
9 down by then. What the predicted bioassay allows you
10 to do is select some dates in between there. The black
11 is relying on the dates that the sample was done. The
12 green, you can select dates to see what the model
13 predicts to see if it is realistic. In this case, in
14 between there you can see where the urine should have
15 jumped way up and then been coming down by the time
16 that first sample was taken, after -- so you get the
17 idea of what you're saying from this intake regime,
18 what you're predicting.

19 The last thing I wanted to show you was I got a split screen
20 here of -- back to that bioassay screen, and I wanted
21 to show you the utility of graph and why a picture's
22 worth 1,000 words. Off to the side here, this is a

1 graph of urinalysis for a particular individual uranium
2 exposure over -- over time, various different intake
3 regimes. A number of intake regimes were put in, IMBA
4 calculated the values for the urinalysis and this is
5 what he -- the black line versus the blue dots or how
6 it fit together. It seems fairly reasonable on this.

7 Down below here the blue dots are lung counts that were done
8 on the person. The intakes were not determined from
9 lung counts. They were determined in this case from
10 urinalysis, and then the lung count data was predicted,
11 and that's the green line you see up here. And you can
12 see the green line doesn't seem to match the blue lines
13 very well at all. It seems to be considerably higher.

14 That pretty much tells the dosimetrist, you know, some
15 of the assumptions are wrong somewhere. In this
16 particular case, this was assumed to be a type S
17 material, and IMBA then allows you to go back, change
18 the solubility assumption to, in this case, type M,
19 redo the same thing, and you can see there that you can
20 not really tell any difference in the fit. You can fit
21 urinalysis data very well with type S or type M,
22 different quantities, but the intake regime was the

1 same.

2 The lung count data, on the other hand, when you compared,
3 all of a sudden that green line fits right through all
4 the blue dots. It seems to be most realistic in this
5 case to be type M type material.

6 And that's pretty much it. I'm looking at a lot of stone
7 faces and no questions. I know it's a dry topic --

8 **DR. ZIEMER:** I'm trying to see where the -- where are the
9 data points in those two lower curves? Are they down
10 near the axis? Is that what --

11 **MR. ALLEN:** Yeah, there's a row of data points right there -
12 -

13 **DR. ZIEMER:** Okay, I see.

14 **MR. ALLEN:** I put the axis in that situation -- I mean I
15 could have spread it out a little more, but I put the
16 axis so I could get this green line on the screen. And
17 then in this case, I just wanted to compare apples to
18 apples. I left the axes the same.

19 **DR. ZIEMER:** Okay, thank you very much. Let's open the
20 floor for questions. Tony.

21 **DR. ANDRADE:** Dave, you mentioned in one of your screens
22 there that either the model predicted points below the

1 detection limit or data were entered that were below
2 the detection limit. Which was which and can you
3 explain that to me again? That one kind of took me by
4 surprise.

5 **MR. ALLEN:** Went by a little fast?

6 **DR. ANDRADE:** Yeah.

7 **MR. ALLEN:** That was measured values below the detection
8 limit, so --

9 **DR. ANDRADE:** Measured values?

10 **MR. ALLEN:** In other words -- example, somebody got a
11 urinalysis and the results were less than one picocurie
12 per day or some value --

13 **DR. ANDRADE:** Right.

14 **MR. ALLEN:** -- you can put in that value and say it was less
15 than. That's what the program allows you to do.

16 **DR. ANDRADE:** But wouldn't a reasonable health physicist
17 have a decision limit that's greater-than? I mean
18 using classical statistics, okay, not Bayesian, but
19 classical, wouldn't you have a detection limit that's
20 certainly somewhere way above your -- I mean a decision
21 limit way above your detection limit?

22 **MR. ALLEN:** Yes, you would. Unfortunately, a lot of cases

1 we have, there's going to be no detectable samples.
2 We're stuck with a lot of less-thans. This at least
3 allows us to plot them out and saying they're less-
4 than. If -- if there's enough detectable sample that
5 we want to ignore what was less-than, we can exclude
6 those with the exclude type and see how everything fit
7 with what was actually detectable and make sure that's
8 reasonable for that situation. There's a number of
9 options that are available there.

10 **DR. ANDRADE:** Okay. So you're artificially establishing a
11 floor that's actually below your detection limit for
12 your system.

13 **MR. ALLEN:** No, actually what it's doing is it is using a
14 maximum likelihood method on the fit and by
15 establishing it -- the value is less than detection
16 limit, it says it has to be in that range between --
17 somewhere in that range between zero and the detection
18 limit. That way it tries not to fit it. If it's going
19 to come out way above that, it's not going to try to
20 predict that intake. It'll predict one that's going to
21 put it down below there, but it doesn't give a lot of
22 weight to it, just somewhere in that range.

1 **DR. ANDRADE:** Thank you.

2 **DR. ZIEMER:** Jim and Gen.

3 **DR. MELIUS:** Gen was first.

4 **DR. ROESSLER:** I have a question with regard to the IMBA
5 history. You mentioned that NRPB developed these
6 biokinetic models using the new ICRP models in about
7 1994?

8 **MR. ALLEN:** Well, 1994 was the lung model published -- when
9 the lung model was published. NRPB did play around
10 with some computer models before that, and that
11 accounts for some of the values in that publication.
12 Those for the most part came from Allen Birchell*, who
13 works for NRPB.

14 **DR. ROESSLER:** And then you mentioned that the IMBA models
15 or model was developed. Was that done by NRPB?

16 **MR. ALLEN:** Yeah. NRPB copyrighted the calculational model
17 that they use for the LUDEP and the lung model.

18 **DR. ROESSLER:** And then -- and when -- when was that?

19 **MR. ALLEN:** The copyrights -- the individual models I
20 believe were copyrighted at various times. It's
21 actually several modules, one of which is a lung
22 deposition*, one is a --

1 **DR. ROESSLER:** It's more recently, though, I guess?

2 **MR. ALLEN:** Excuse me?

3 **DR. ROESSLER:** More recently?

4 **MR. ALLEN:** Probably post-'94 when it was copyrighted. And
5 then as the biokinetic models were developed, they
6 copyrighted new modules.

7 **DR. ROESSLER:** Up to this time, up to your presentation, I
8 was thinking that NIOSH had developed IMBA. What
9 you're really doing, you're using the program developed
10 by NRPB.

11 **MR. ALLEN:** Right, what it amounts to is copyrighted
12 software -- or copyrighted calculational engines, and
13 we asked for the front end -- everything you see pretty
14 much, we asked for that to be developed, a user
15 interface.

16 **DR. ROESSLER:** My real question is who validated the model?
17 Did NIOSH do anything -- I mean I want to know if it's
18 working right, and I know NRPB probably did, but I'm
19 wondering what you did to -- to validate it to make
20 sure that that's the model you wanted to use and that
21 you're getting the right answers.

22 **MR. ALLEN:** Right. NRPB did a lot of V&B* on it, quality

1 control, every time they develop a new model on there,
2 they do a lot of quality control. Also they were
3 pretty much the only thing that had any sort of
4 credibility or V&B out there at the time we were
5 looking for something. And when we get in a new
6 version, what we've done is used the committed dose
7 section of that. We can put in -- at one becquerel
8 intake, use the committed dose and see if we get the
9 right effective and the right organ doses according to
10 NRPB publications, and that's what we're claiming to
11 use is NRC -- NCRP models -- I'll get it right -- ICRP
12 models. We're claiming to use the ICRP models. The
13 program with the particular input gives us the right
14 output that we can tell from those publications, and
15 that's -- that and maybe a little bit of more
16 validations is about all we manage to do in-house, but
17 we have the NRPB quality control documents, also.

18 **DR. ZIEMER:** Jim, then Mark.

19 **DR. MELIUS:** Well, actually Gen asked one of my questions,
20 though I'm still a little bit concerned with just the -
21 - the validation issue. So -- so how do we know that
22 this is giving you the right -- the correct answers for

1 other situations? I mean it -- assume there's been
2 more to the quality control that went into developing
3 this than -- than what you described.

4 **MR. ALLEN:** NRPB has put a lot into it. What we've done in-
5 house is -- first thing is to -- for each isotope, we
6 put in one becquerel and see if the effective dose is
7 what's -- matches what's in the publications. Also see
8 that the committed dose to organs matches what's in the
9 publications. After that, we've determined -- we
10 calculated annual dose for 50 years, put them in Excel,
11 added them up and made sure that matched. So it's --
12 you know, annual doses at least match -- or add up to
13 the 50-year committed dose.

14 We've also -- using ICRP-78 where we can with the dates that
15 are in 78 for bioassay, we can predict bioassay -- put
16 in, you know, standard input, like a one becquerel
17 intake and predict what the bioassay should be at five-
18 day, ten-day, 100-day, whatever's in the ICRP
19 publication, and we can verify that that matches with
20 the publication. And we've done a little bit of work
21 matching up with -- Potter published a whole magazine
22 of tables for bioassay analysis and we've done some

1 spot-checking against that.

2 **DR. MELIUS:** Secondly is the issue of how you use it, and I
3 guess I'm a little -- well, I don't -- confused or
4 concerned, but at one point you mentioned that you're
5 going through and when you find an outlier, you exclude
6 it.

7 **MR. ALLEN:** The option's there for the dosimetrist.

8 **DR. MELIUS:** Okay. But is that what you -- you're actually
9 doing? 'Cause I mean I --

10 **MR. ALLEN:** It can be. I mean errant bioassay samples do
11 happen. There's not unusual to even get a number of
12 samples, you can watch urinalysis coming down from an
13 acute intake and then one of them's zero.

14 **DR. MELIUS:** Yeah.

15 **MR. ALLEN:** The next one seems to be following the curve.
16 That zero, if you assume it's real and the computer's
17 looking at it, it's going to drive that intake down to
18 try to fit the data, so the dosimetrist is allowed to
19 exclude that and see if the data fits better without
20 that anomaly.

21 **DR. MELIUS:** Yeah, but then what -- how do you take that
22 into account when you're doing your actual dose

1 calculation? How do we know that your assumptions --
2 your assum-- that you're excluding it 'cause it's a bad
3 bioassay sample versus that you're making the wrong
4 assumptions because of the -- you have poor
5 information? And then how does that get into --
6 eventually get into the IREP model as -- in terms of
7 your certainty about that dose? I guess -- and I'm
8 going for -- trying to get at how much, you know,
9 individual, you know, (Inaudible), if ten different
10 health physicists used the same data, would they all
11 come up with the same, you know, calculation or --
12 yeah, yeah, that's --

13 **MR. ALLEN:** For internal dosimetry, no. You will get ten
14 different answers. Hopefully they'll get the -- our --
15 our job is to make sure we get the same side of 50
16 percent probability. The dose should be reasonably
17 close, the intake.

18 For the most part, as far as the uncertainty, at this point
19 we can -- I can answer that that we've avoided it. For
20 the most part we have tried to overestimate or
21 underestimate bioassay. When we have data on a curve
22 or data showing on a curve that's considerably higher

1 or considerably lower than that data point's indicating
2 that it's definitely an overestimate or definitely an
3 underestimate, therefore we can bound the intake that
4 way. And that's probably going to be a big portion of
5 the cases. We can bound it that way and not deal with
6 the -- you know, whether it's ten percent error or 50
7 percent error or whatever.

8 **DR. MELIUS:** No, I -- I understand that part. I just get
9 concerned about the ones that you can't do that on and
10 where your assumptions are going to be sort of critical
11 to the outcome of that case, and sort of how do we get
12 consistency in doing it, I think is the -- is the
13 issue. I think Tony has a...

14 **DR. ZIEMER:** Mark and then Tony.

15 **MR. GRIFFON:** I have a pretty straightforward one. What --
16 in this newest version, what are the radionuclides
17 available now? I know in -- I saw a recent version and
18 it had just limited radionuclides built in and I wonder
19 if -- if you've got all the radionuclides you need for
20 this program available now.

21 **MR. ALLEN:** We have about -- I believe the number's 54 now
22 in there. It's all the important ones you would want

1 with DOE complex and probably not every single one.
2 There's always an odd case out there, especially at a
3 national lab. For the most part, what's missing either
4 has a short half-life or a short biological half-life,
5 and we can use the 50-year committed published doses --
6 the person got it all in the first year and we can
7 simply use that without the computer program.

8 **DR. ZIEMER:** Tony?

9 **DR. ANDRADE:** Dave, certainly within the laboratories we
10 have ways of ensuring that the spikes and the zeroes
11 are true or not true. We run blanks and we also run
12 spikes, along with the real bioassay samples. And that
13 is true for both alpha spectroscopy as well as for mass
14 spectrometry. And I guess my question to you is do we
15 pass along or do you use all of the raw data that we
16 collect? Or do you use our final values?

17 **MR. ALLEN:** We ask for the raw data and that's what we use.

18 **DR. ANDRADE:** Okay.

19 **MR. ALLEN:** If we can -- all the way down to counts per
20 minute if that's what we can get, but that's pretty
21 rare to get ahold of that. That's generally going to
22 be a urinalysis result in say dpm per day or whatever

1 the appropriate unit is for that particular isotope,
2 and that's what we start with.

3 **DR. ANDRADE:** Okay.

4 **DR. MELIUS:** Yeah, the issue's been brought up before here
5 about the accessibility of this software for people
6 that are not directly involved in the program, and I
7 may be wrong, but I thought Larry or somebody was going
8 to look into that issue. Am I remembering wrong? I
9 don't want to put you on the spot, but -- or have we
10 thought about that more or -- that whole issue?

11 **MR. ELLIOTT:** We've already answered that.

12 **MR. ALLEN:** I've encouraged the vendor to make a publicly-
13 available version that he can sell. They are looking
14 at that. They have not made one yet. There is a
15 version they're putting together called IMBA
16 Professional, and he's trying to put together a light
17 version -- is what he calls it, IMBA Professional Light
18 -- that has much fewer functions that might be --
19 possibly be affordable is what he's shooting at. That
20 is not available yet. He is -- they're -- haven't
21 sorted that out, but individuals would have to buy or
22 organization or whatever, 'cause there's licensing

1 issues with the copyrighted software.

2 **MR. GRIFFON:** And how -- just to follow-up on that, how
3 about availability to the Board or to the
4 subcontractor, can --

5 **MR. ELLIOTT:** You -- the Board and your contractor, as well
6 as our contractor, all have access to the IMBA-NIOSH --
7 or IMBA-OCAS as special government employees or as
8 contractors to the government on the program. But Dave
9 is actually right and accurate in his statement. The
10 ICRP models and the calculation engine from NPRB (sic)
11 are copyrighted and protected and we can't distribute
12 those to the public without a user's license, and
13 that's the issue. Somebody has to pay for that.

14 **MR. GRIFFON:** And you say they're available to the Board. I
15 mean can we -- can we physically get a copy sent prob--
16 before the next meeting or how can we move forward on
17 this? It'd like to get a disk copy sooner than later.

18 **MR. ALLEN:** It can be done. We've got -- I don't know how
19 we'll work out the details on -- the licensing
20 agreement allows NIOSH to use it and any of its
21 subcontractors for the purposes of the OCAS --

22 **MR. ELLIOTT:** Am I correct, it's not in a CD form, though,

1 it's in a -- it goes on a server. Right?

2 **MR. ALLEN:** No, it's in a CD.

3 **MR. ELLIOTT:** It is in a CD.

4 **MR. ALLEN:** Yeah.

5 **MR. ELLIOTT:** Okay. Well, we'll get that --

6 **DR. ZIEMER:** Okay, you can work with them then and --

7 **MR. GRIFFON:** Okay.

8 **DR. ZIEMER:** Yeah, Mike has a question here.

9 **MR. GIBSON:** Can you tell me -- do you know off-hand how
10 much of the data you get from these DOE sites is
11 assumptions, default factors, solubility class, the
12 date of intake?

13 **MR. ALLEN:** For the most part, if it's bioassay -- that's
14 why we want the raw data. If it's bioassay analysis,
15 it's a mass spec or an alpha spec or even a gross
16 alpha, that's -- counts or activity in that urine, for
17 example. There's no assumptions that went into it.
18 It's a laboratory analysis. And then from there we
19 have to make the assumptions as far as solubility and
20 all that. And the assumptions we use are the reason we
21 have to put together these site profiles that was the
22 last lecture. We have to have some idea of what

1 material they had so that we know what type of
2 solubilities that would be associated with it, and then
3 we make sure that the bioassay actually fits that data,
4 if the assumptions are accurate or not.

5 **MR. GIBSON:** But your -- are you looking at the date of the
6 bioassay -- was taken or --

7 **MR. ALLEN:** Yes. Yeah, we -- we get the date that a sample
8 was taken; you know, what was taken, such as a urine
9 sample; how much, was it a 24-hour sample or was it a -
10 - you know, an allotment; the actual results, such as a
11 gross alpha or it could be picocuries per liter of
12 plutonium, for example; what isotope if they have that.
13 Everything we can get, we get. We're not shy about
14 asking for it.

15 **DR. ZIEMER:** Okay on that, Mike, or did you have a follow-
16 up?

17 **MR. GIBSON:** I don't know if I understand it all, but I --
18 that'll answer for now, yeah.

19 **DR. ZIEMER:** And you're saying basically you're not
20 utilizing assumptions that may have been made on the
21 site 'cause on the site they also presumably do some
22 sort of dose calculation, in many cases the 50-year

1 committed dose --

2 **MR. ALLEN:** Using ICRP-30 models --

3 **DR. ZIEMER:** Right.

4 **MR. ALLEN:** -- so what they've used -- the doses they've
5 calculated are not necessarily good for us, and very
6 few sites have ever calculated an annual organ dose.

7 **DR. ZIEMER:** So you don't find there's any value in looking
8 at what they may have ultimately calculated for tissue
9 dose or organ dose?

10 **MR. ALLEN:** There could be some value in it, especially -- I
11 mean information's always limiting, and if that's all I
12 can get is a calculated dose, you can pretty much -- if
13 you get enough details, you can back-calculate what the
14 bioassay was that that came from. Also as far as the
15 solubilities, same general -- you know, we hope that
16 we're not complete ends of the spectrum on what they're
17 -- have been assuming and what we're going to assume.
18 There should be some reason if there's a -- if we're
19 completely different.

20 **DR. ZIEMER:** He's got a follow-up.

21 **MR. GIBSON:** If you had like a super-Y class of plutonium,
22 how would you be able to distinguish that or could that

1 mask your raw data out of the bioassay...

2 **MR. ALLEN:** It really couldn't mask the raw data, but it
3 could mask the dose and the intake that you're
4 calculating from the raw data. And the way that can be
5 handled -- as I said, we have default classes that can
6 be picked, but we can also input our own user input.
7 For us to use a super class-Y plutonium, we would
8 probably put together a Technical Information Bulletin
9 evaluating a particular site, what they had, saying the
10 solubility doesn't follow the defaults and we have more
11 information, and in that case use these absorption
12 parameters for this site, is how we would handle that,
13 and we haven't done that yet. What's -- we haven't
14 changed from any defaults yet, but we're still kind of
15 young into that part.

16 **DR. MELIUS:** Just one -- I think it's a brief question, but
17 back just to the validation. Have you documented the
18 validation you've done?

19 **MR. ALLEN:** Part of our contract for the upgrade is a whole
20 documentation on all the V&B that NRPB has done.

21 **DR. MELIUS:** Okay. And then your further --

22 **MR. ALLEN:** Our further evaluation, we have documented not

1 in a very formal manner, okay? That's one of those
2 things you just never seem to get to. We've got all
3 the numbers and it's a matter of writing down something
4 and documenting it.

5 **DR. MELIUS:** I just think that would be helpful to do. I
6 know it's hard to get to, but it's one of those things
7 -- things that I think at some point, if questions are
8 raised, it would be good to have.

9 **MR. ALLEN:** Yeah, I understand. It's just once you get --
10 once you have run the numbers, you know it works, the
11 actual --

12 **DR. MELIUS:** No, I -- I --

13 **MR. ALLEN:** It tends to get pushed to the back burner.

14 **MR. GRIFFON:** Yeah, just one final thing on the validation
15 side of it, do you know if there are any plans to
16 update the CINDY* code to be ICRP-60/66 compatible? I
17 know right now it runs in 30, and if that's going on,
18 that may be another tool that you can validate against
19 or whatever. I don't know if that's happening.

20 **MR. ALLEN:** I don't know if that's happening. I haven't
21 heard of that. I know there is a number of -- a number
22 of other codes out there. For the most part, they're

1 kind of home-brewed. Like Potter put one together, and
2 there's someone else that put a math CAD-1 together, I
3 think, and --

4 **MR. GRIFFON:** French or --

5 **MR. ALLEN:** Nothing that's very versatile for what we're
6 doing.

7 **DR. ZIEMER:** Tony.

8 **DR. ANDRADE:** A quick answer to Mark's question. When we
9 were asked by DOE to assist in the development of IMBA,
10 we were all forced to shell out some big bucks, and so
11 in doing so DOE elected for us to invest in this
12 particular code. So if CINDY is being upgraded, then
13 it's got to be getting done sort of at a -- at the
14 grassroots level somewhere.

15 **UNIDENTIFIED:** Good answer.

16 **MR. GRIFFON:** Just -- just one final question, Paul. I'm
17 curious if you've -- just in individual cases, you
18 mentioned bioassay data a lot. Have you had the
19 occasion to use air sampling data to validate your dose
20 calculations from your bioassay, and I don't know how
21 often you're able to get the air sampling data that
22 might be appropriate for certain individuals, but have

1 you had the -- have you done that frequently or --

2 **MR. ALLEN:** No. I would love to, but getting the air sample
3 data, especially from like a major DOE facility and
4 correlating that to an individual throughout a 20-year
5 career is virtually impossible. We can get some ball
6 park estimates if we could get the data, but because it
7 wouldn't be that useful in that situation, we haven't
8 gone -- trying to get it. It's also fairly difficult
9 to get ahold of, as far as 20 years, 30 years back.
10 You can get some general ideas, but the details is hard
11 to --

12 **MR. GRIFFON:** I'm not sure I agree with the it wouldn't be
13 very useful part of that statement, but otherwise I
14 agree with you. I mean -- I mean I think there might
15 be some usefulness for certain priority operations or
16 areas within certain sites to have that as a backdrop,
17 and if you knew a person worked in that facility over a
18 certain period of time, you could do some cross-checks
19 or -- and I certainly have noticed also that that's
20 lacking in the site profile documentation, too, so I
21 would encour-- I think that's a useful tool to -- if
22 nothing el-- I mean I know it's probably going to

1 increase your uncertainty in your overall estimate in
2 many cases, but it's another piece of information, as
3 you said earlier, which I -- you know, it may be
4 valuable in certain circumstances.

5 **DR. ZIEMER:** Thank you. We're at the lunch hour. I think
6 it's appropriate now for us to recess for lunch and
7 we'll come back together at 1:30.

8 (Whereupon, a luncheon recess was taken.)

9 **WORKGROUP ON OPTIONS FOR EVALUATING INTERVIEWS**

10 **DR. ZIEMER:** Thank you. We're ready to call the
11 meeting back to order. I trust you all had a good
12 lunch and are ready for another working session.
13 We're going to begin our afternoon session with a working
14 report from our workgroup on options for evaluating
15 interviews. Dr. Melius has been the Chairperson of
16 that workgroup and he's going to report to us and
17 perhaps make a recommendation.

18 (Pause)

19 Okay, Dr. Melius.

20 **DR. MELIUS:** Okay. Since our last meeting in St. Louis, the
21 workgroup has had one additional conference call -- was
22 it last week? Yeah, last week, Wednesday. We met by

1 conference call and discussed -- and had received some
2 additional information from NIOSH, which were the --
3 basically the ORAU procedures for doing the interviews
4 and scheduling the interviews and so forth. Based on
5 the information that we had received and I think
6 recognizing that -- that NIOSH's and ORAU's program to
7 sort of review the interviews and some of the quality
8 assurance/quality control measures were a work in
9 progress -- they were developing these really as -- as
10 we were meeting, and as the program was getting --
11 getting implemented -- we've -- came up with a set of
12 recommendations which I think everyone has in front of
13 them here about things that might -- these covered two
14 areas. One is things that NIOSH might do as part of --
15 and actually it may currently be -- already be doing as
16 part of its quality assurance/quality control program
17 for the interviews -- that would be helpful for the
18 Advisory Board if some of this -- these steps were --
19 or procedures or events were captured in some way as
20 part of a -- the database so that we would be able to -
21 - the Board would be able to go back at some point in
22 time and evaluate these or our contractor might as a

1 way of evaluating the interview process in the context
2 of the dose reconstructions that are going on. And so
3 we've made a basic recommendation there to -- to NIOSH.

4 It's not meant to be overly prescriptive for NIOSH,
5 but to -- that basically the program be further
6 developed and that -- and we've given some examples of
7 things that might be captured. Almost all of these
8 examples are things that NIOSH -- in fact all of them
9 may be very well things that NIOSH or ORAU is already
10 doing. And the question is just to make sure that
11 there is some record that keeps track of these, and in
12 some sense a tracking system is -- that would allow
13 review.

14 The second part of our recommendation is that -- then --
15 that as part of the dose reconstruction -- dose
16 construction review process that would undertake that
17 then as currently cons-- currently described, this --
18 our dose reconstruction will be -- program review will
19 also be evaluating the outputs from the interview, the
20 way the interviews are recorded, and also some of the
21 other information that's kept in the individual record
22 to that. And so that's what's captured in this second

1 recommendation there.

2 Now I've circulated this to the members of the working
3 group, also to Paul. Paul's listened in and
4 participated in our last conference call. I really
5 didn't receive any comments or corrections from the
6 workgroup, but they're free to correct or whatever as
7 we go along, but -- but I think it's more important
8 sort of the concept -- again, to go back, what we're
9 trying to deal with is the issue of should there be --
10 should the Board be either repeating or taking some
11 steps that would be more intrusive in terms of
12 evaluating the interview process, be that a second
13 interview, independent interview, a review of a
14 transcript of an interview or recording of -- of
15 interview and that the Board is probably split on that
16 issue as to whether or not that should be done or
17 whether that's too much of a intrusion or imposition on
18 the people that -- on the claimants and so that these
19 steps in place and based on the results of -- of this
20 review, then the Board at a later point in time could
21 make an assessment as to whether or not a more
22 intrusive form of review of the interviews might --

1 would or would not be necessary.

2 I don't know if any other members of the working group have
3 any comments you want to add to that.

4 **DR. ZIEMER:** Okay, before we take comments, the Chair is
5 going to interpret this as a recommendation -- it is a
6 recommendation from a working group and as such
7 constitutes a formal motion before the Board, doesn't
8 require a second. And so with that as background, we
9 can have comments, which could include modification.

10 Let me also add, and as Jim indicated, I did listen in on
11 this and I want to make sure -- particularly that the
12 NIOSH staff understands that this Board is not
13 mandating specific things that NIOSH do. We do not
14 want to micro-manage NIOSH. The -- as I understand the
15 intention of item one and the list of (a) through (f)
16 is that in fact these are the kinds of records we would
17 like to be able to sample as a Board, and if they
18 existed, we would then in turn be able to evaluate the
19 -- the process, the interview process more readily.

20 Whether -- I think we believe that probably most of
21 these exist in some form -- either formally or
22 informally -- but the whole idea there was to identify

1 the kinds of things we -- that probably the Board would
2 want to sample that would make it much -- make the
3 audit more readily conductible. Is that a fair --

4 **UNIDENTIFIED:** And informative.

5 **DR. ZIEMER:** And informative. Is that a fair statement,
6 Jim?

7 **DR. MELIUS:** Yeah, and -- and --

8 **DR. ZIEMER:** And let's begin with Wanda, and then we'll jump
9 down to Tony. And you can speak for or against the
10 motion or modify or just comment.

11 **MS. MUNN:** My apologies for not having gotten back to our --
12 our working group chair with a couple of comments that
13 I had. I think they were both captured by comments
14 that we made during our actual discussion, but I felt
15 perhaps were not fully gathered here. I had thought we
16 might meet once more before we actually presented
17 anything in writing to the group and -- but most of --
18 most of what I had -- had -- most of the changes I had
19 made were purely editorial. They didn't change the
20 sense of what was going on here.

21 The one thing that I did not feel was captured that -- was
22 the suggestion that I made, which remains important in

1 my mind, that it would be most helpful from an auditing
2 point of view to have a single document where a record
3 had at least been signed off on by individuals who had
4 done these specific actions that were listed here. I
5 don't think that such a document would be an undue
6 burden if it went along with the case file, wherever it
7 went. But that's something that certainly would be
8 simply a suggestion as a potential tool that might be
9 considered. And I can see no reason why it would have
10 to be written, necessarily. It's --

11 **DR. ZIEMER:** Wanda, are you suggesting a specific change? I
12 seem to recall you characterized that as a tracking
13 system in the phone call. Was that --

14 **MS. MUNN:** Yes.

15 **DR. ZIEMER:** Am I thinking about the right thing?

16 **MS. MUNN:** Yes, you are. Yeah, I was thinking about a
17 specific document that would serve as a tracking
18 document.

19 **DR. ZIEMER:** Well, is that item (f) or is that different
20 than item (f)?

21 **MS. MUNN:** Well, I think -- I interpreted item (f) to
22 incorporate that, but perhaps -- if one had not heard

1 the discussion, I thought just reading (f) as it was
2 perhaps would not make it as clear as what I had in
3 mind. I had a simple sheet of paper in mind which
4 would be a check-off or a sign-off document for various
5 steps that needed to be gone through, which were over
6 and above the mechanical processes that are done
7 electronically. But no, I'm not asking for any
8 changes. I just wanted a clarification statement.

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

10 **DR. ANDRADE:** With respect to Wanda's comment, I would just
11 like to say that if -- if an electronic system is put
12 into place, such as we suggest here, then a paper which
13 would essentially be a traveler, as we call it, could
14 be generated from that electronic system's -- at any
15 particular point in time, at -- with any particular
16 case, such that the audit function would be very, very
17 easy to accomplish. So I think that if we can
18 accomplish what's written down in item (f), then the
19 paper document would be a natural. It'd be -- it would
20 follow on naturally.

21 Again, in keeping with what Paul said, I, too, do not want
22 to be overly prescriptive or to try to dictate the work

1 that -- that NIOSH should do. However, I did want to
2 point out that a QAQ (sic) system is -- is really meant
3 for those people that are implementing these -- these
4 processes. It's meant for their own quality
5 development and improvement. And therefore we should
6 not lose sight of the fact that NIOSH should own the
7 program, should evaluate the program. ORAU should be -
8 - should use the procedures that are developed, and
9 that the Board should also keep track of what's going
10 on. And I believe this is also an item for our
11 subcontractor to look at. Am I wrong?

12 **DR. ZIEMER:** There is part of the task which is --

13 **DR. ANDRADE:** There is part of a task there might --

14 **DR. ZIEMER:** -- this, and in fact when we're talking about
15 doing this in terms of "us", that includes our
16 contractor.

17 **DR. ANDRADE:** Right. Okay. I, too, wanted to hand over a
18 couple of -- both editorial and maybe one or two
19 substantive comments, and I don't know if this is the
20 appropriate time to delve into those.

21 **DR. ZIEMER:** That's fine.

22 **DR. ANDRADE:** Okay. I try to skip over the editorial piece.

1 Let me just get back to the very last paragraph in
2 this draft document, and it refers to the fact that --
3 I think next to the last -- sorry, the last sentence.
4 However -- it reads: However, the need for this should
5 be re-evaluated at a later time -- and we're talking
6 about re-interviewing claimants -- based on the results
7 of the dose reconstruction review and the
8 implementation of the QA/QC program described above.
9 Well, QA/QC is meant for quality improvement, meaning
10 improving processes into the future. They should not
11 be looked at as an avenue to go back and look at things
12 retrospectively. Which brings us to the heart of the
13 matter.
14 I think that we as a Board should vote and should decide
15 once and for all whether re-interviewing is actually
16 even on the table. I believe it shouldn't be. I
17 believe it's onerous. I believe that the only people
18 that are going to be called are those people who have
19 had their claims rejected and that it's going to be
20 just a heart-wrenching experience for those people.
21 And I really don't see any tremendous incremental value
22 added in even thinking about that.

1 So with that, you know, I would -- I would essentially vote
2 for taking out most of that sentence, starting with the
3 word "based". But of course that really can't be done
4 until this Board comes to -- comes to grip with that
5 issue, and I really do believe that we should do that.

6 **DR. ZIEMER:** Tony, I'm not sure whether you're making a
7 motion to amend or simply at this time reflecting that
8 viewpoint...

9 **DR. ANDRADE:** Well, I --

10 **DR. ZIEMER:** Could you clarify for me?

11 **DR. ANDRADE:** Okay, Paul. I guess there'd be a two -- two-
12 phased approach to this. One is, I think that the
13 Board should discuss whether or not retrospective or
14 re-interviewing is even on the table for us to
15 consider. That's one.

16 And if it is not, then I would move to amend the draft as it
17 -- as it -- as it stands, at least for the --

18 **DR. ZIEMER:** Yeah, I might point out that it -- it may turn
19 out to be a moot point whether or not we include it in
20 this document. The Board could always -- even if this
21 were deleted, the Board could at a later date decide,
22 for whatever reason it wished, that something different

1 should be done. We're not binding ourselves in one
2 direction or the other. I suspect that the statement
3 as it stands simply points out that the door could
4 still be open for that possibility in the future.

5 You're suggesting let's not even open it --

6 **DR. ANDRADE:** I don't think we --

7 **DR. ZIEMER:** -- and I'm saying that even if we did that,
8 there would be nothing to prevent the Board in the
9 future from changing its mind in any event. And I say
10 that in the context where I myself have been basically
11 opposed to the idea of re-interviewing, if only for the
12 fact that a re-interview is not in fact the same as the
13 original interview. It is different in time and in
14 pla-- space. The interviewer would be a different
15 person than the original one, presumably. You could
16 not reproduce the conditions of the original interview.

17 You might in fact elicit different responses from
18 interviewees. You might elicit things that the
19 interviewee did not even think of the first time
20 around, so it's very difficult for me to imagine a re-
21 interview as a quality check on the original interview
22 so much as these items, which are a way of getting at

1 the issue of whether or not the information from the
2 interview was properly captured and used in the record
3 and in the determination of the eligibility of the
4 person for compensation.

5 But be that as it may, I think we need to hear from others.

6 I guess you're not making the motion at this time, or
7 are you?

8 **DR. ANDRADE:** No.

9 **DR. ZIEMER:** Okay. Thank you. Okay, let's start with
10 Henry, and then Mark and then Jim.

11 **DR. ANDERSON:** Yeah, I'm -- I think the recommendations are
12 good ones. I think the decision as to whether one
13 would re-interview -- I think this basically sets that
14 aside, because it'll depend on what the QA/QC program
15 is that we need to know is where -- is a second set of
16 ears sitting in and listening interacting then to
17 improve the interviews as they go forward, if the set
18 of ears is saying we're going to listen on every
19 interview, but each interview only has 20 seconds worth
20 of listening in, then you know, we sort of need to know
21 is the person going to listen to the whole interview
22 and then, you know, comment back to the interviewers

1 'cause they're all learning as they go anyway. I think
2 part of the QA/QC how -- how it's designed would
3 relieve a great deal of concern about the interview.
4 And I think that's kind of why I support this language
5 that I think what we're basically saying here is that's
6 an option, but we aren't -- we don't need to really
7 think about that till we see, gee, if you look at all
8 these interviews, if there doesn't -- if they don't
9 seem to be generating anything or everybody's in
10 agreement, then I don't think we'd move forward. So I
11 really think we need to have this for a kind of an
12 audit trail so that when our people come in they can
13 look at this and say yes, this one was -- somebody did
14 listen in and so when we look at it, there was
15 agreement between the person who listened in with the
16 interviewer as to how the information was recorded and
17 what was heard. So you know, our earlier discussion
18 about should our person sit in and listen and take
19 notes, here their internal auditor is doing that and
20 it's a question of then seeing how is that used or how
21 extensive is that -- that listening in and what is the
22 feedback loop for it. So I -- I think what's here is -

1 - is a good first step and it'll help us down the line
2 when we look at inter-- an interview and say gee, you
3 know, there doesn't seem to be much here. I wonder --
4 or something like that. We would have that answer in
5 whatever the audit program was, so that's why I think
6 it's very helpful and I -- I don't -- you know, I'm --
7 I'm assuming or I'm hoping that whatever is designed
8 and shared with us, we would view that, after the fact,
9 as being sufficient for us not to be concerned about
10 the interview process. But that -- that's a -- yet to
11 be determined till we get into actually looking at the
12 individual cases or our contractor starts generating
13 that to say gee, here's some improvements we might want
14 to recommend.

15 **DR. ZIEMER:** Thank you. Mark?

16 **MR. GRIFFON:** Yeah, I guess the first thing that strikes me
17 in this -- in these recommendations is that it -- it's
18 really recommending internal audit as opposed to a
19 Board audit. And Tony is right that the tasks as we
20 laid them out for the subcontractor right now do
21 include a review of the procedures and the interview
22 form. And I think that'll be telling -- once we

1 initiate that, we may have some good input and sense of
2 that.

3 I guess I expected that these audit recommendations and the
4 listening in, as Henry described it, might be a Board
5 function. I'm sorry -- and -- and then the other --
6 you know, I would also -- I think that last language,
7 the re-interviewing, I don't know if the notion of
8 requiring taping -- I know we had some early
9 discussions about that and there are some complications
10 about that. I don't know if the working group
11 discussed that any further. You know, pending the
12 outcome of the initial review of the procedures and the
13 interview form and maybe of this internal audit, you
14 know, we may -- we may want to go to -- and I know
15 there -- there's hurdles to get over for that, but we
16 may want to go to a function where we tape some of
17 these interviews and then we can audit them in that
18 fashion instead of re-interviewing, necessarily --
19 'cause I know there's certainly pitfalls with the re-
20 interviewing process, but -- but - but I guess -- one
21 think I would ask the working group is, you know, this
22 being an internal audit by NIOSH, did -- did you have

1 discussions about the Board doing this -- these steps
2 (a) through (f) or whatever?

3 **DR. MELIUS:** Yeah, let me -- 'cause --

4 **MR. GRIFFON:** Or maybe I just need clarification, I don't
5 know.

6 **DR. MELIUS:** Yeah.

7 **MR. GRIFFON:** Yeah.

8 **DR. MELIUS:** I think if you look at this -- I may have
9 mischaracterized it. One and two is the NIOSH program.

10 If you go to the last -- is what NIOSH will do is a
11 QA/QC program to improve -- be improving the interview.

12 If you go to the last paragraph, it's what the -- what
13 we're doing, the Board is doing and doing that, and
14 that was really another working group and the Board
15 that is laid out the parameters for that and I think
16 we've talked about it at other -- other meetings.

17 And then I think we're making -- maybe the wording isn't as
18 complete as it could be, but we're making a statement
19 that, you know, based on this imple-- implementation of
20 these two things, the NIOSH QA/QC program -- it's
21 called that -- our individual dose reconstruction
22 reviews that involve evaluating the interview record,

1 therefore at this time we're not recommending that
2 there be any further -- more intrusive way of --
3 potentially more intrusive way of reviewing the
4 interviews, whether it be listening in or re-
5 interviewing or reviewing a recording of the interview
6 or -- or how -- whatever that may be 'cause they all
7 raised a number of -- number of issues, you know,
8 beyond what we've talked about here, so -- a big
9 headache for Larry to deal with and some of these could
10 be, anyway. So I think that therefore we're -- you
11 know, this is our recommendation at this point in time,
12 and I think we have to leave it open and see what
13 happens down the road and see what the results of these
14 are.

15 **DR. ZIEMER:** Larry, you had a comment?

16 **MR. ELLIOTT:** Yes, if I might. You've heard me speak about
17 this before, and in the spirit of being helpful and not
18 in the spirit of belligerency or -- or unhelpfulness,
19 these set of recommendations are appropriate, we feel,
20 for an understanding of what it is the Board would like
21 to audit on this piece of the process. Many of these
22 are already in place or being developed. Yes, we want

1 to be very clear that we don't have all of these fully
2 developed and fully functional, but that's the
3 direction that we are going. You've heard me say from
4 the very start that we think the Board's audit should
5 evaluate the interview process and how they contribute
6 to dose reconstructions.

7 Now, just for your benefit, you've also heard me say that
8 re-interviewing claimants is off the table. And it's
9 not this Board's decision at the end that's going to
10 make that -- that'll carry that day. The Department
11 will weigh in on whether or not this actually happens.

12 If you so choose to leave the door open, that's one
13 thing. But if you choose to ask for a re-evaluation
14 and re-interview of claimants, the Department will have
15 to weigh in on that. So I just offer that as helpful
16 perspective, not as a belligerent perspective. I want
17 you to understand, at the end of the day the Department
18 will have to decide the value of that particular
19 component if you choose to re-interview claimants.

20 **DR. ZIEMER:** Thank you. Okay. Let's go right down the
21 line. Leon?

22 **MR. OWENS:** I'd just like to say that I agree with the

1 recommendations by the working group. I think they've
2 done a very good job.

3 In regard to the re-interview process, I appreciate Larry's
4 comments, but I do think that we need to at all times
5 consider the credibility of the program and by making
6 that consideration with the claimants, particularly the
7 elderly, that are not as well-versed in this process as
8 we might be, I think there would be value-added in a
9 re-interview from the standpoint of quality assurance.

10 **DR. ZIEMER:** Thank you. Roy?

11 **DR. DEHART:** We have a proposal here, and I assume that the
12 rationale for that is that we're not sure that the
13 current interview system is working effectively. I
14 would ask the question, having done 20,000 interviews
15 as was presented today, are we aware of any significant
16 problems with the interview process?

17 **MR. ELLIOTT:** I would answer that question this way, that
18 no, we are not aware of any problems in our interview
19 process. ORAU does have the manager of that particular
20 task and other delegated folks in that part of the
21 program listen in -- and it's not just for 20 seconds;
22 it's for the whole interview that -- they listen to the

1 whole interview and feedback is provided.
2 I will also say this, that there have been a number of cases
3 that I have approved to go over to DOL where I have
4 seen how the interview has been captured and utilized
5 in the dose reconstruction, and how it's reflected in
6 the dose reconstruction report. So I'm fairly
7 comfortable and confident in saying to you today that
8 this interview process is a contributing factor to dose
9 reconstruction, and we have not identified any major
10 problems with it. But we're watching it very closely.

11 **DR. DEHART:** I gather from what you had said previously that
12 you're in the process of developing just what is being
13 suggested here, basically -- a way of going through and
14 documenting that the -- basically (a) through (f) --
15 some modifications will be occurring.

16 **MR. ELLIOTT:** Several of these are in place. They're
17 perhaps not at a state of readiness that we are happy
18 with. Some -- a couple of these are not in place, but
19 they're -- we've had similar ideas and we intend to put
20 them into place -- (f) for instance is one -- you know,
21 we don't have in place right now, I don't believe,
22 necessarily, but we do agree it needs to be put to --

1 put in place. And the traveling document, hard copy,
2 would go along with that, so -- appreciate those
3 thoughts and those comments.

4 **DR. ZIEMER:** And if I might add, again, I just observed the
5 work of the subcommittee (sic), I don't think there was
6 an assumption that there was something wrong currently
7 with the interview process. The real issue is how do
8 we carry out our responsibility of evaluating it. And
9 I certainly became aware as we got the materials from
10 Dr. Toohey on -- on what they do and how they do that -
11 - for example, they do have a management tool where
12 they listen in to the interviews. Great, how do we
13 critique that? If the -- is that available for us to
14 look at so we can say what -- what was the evaluation
15 of the listener of that interview. So these things
16 simply reflect the kinds of records that could be
17 audited where we could make a judgment. Yeah, the
18 interview was properly reflected -- and all the things
19 that Larry just described. We want to be able to -- to
20 confirm those kinds of things, how the interviews are
21 used in the dose reconstruction, if indeed they are;
22 how they've contributed to it. So it's a matter of

1 simply being able to document what has been talked
2 about here.

3 We'll go on to Tony, and then we'll circle back again.

4 **DR. ANDRADE:** Okay. Perhaps -- perhaps my comments have
5 been overblown a little bit, or perhaps I overblew them
6 a little bit. If the process that we're suggesting
7 remains internal and a re-interview is -- is -- let's
8 say it's decided by one of the reviewers here in the
9 list that runs from (a) to (d), determines that more
10 information is necessary -- like an internal decision
11 to re-interview is appropriate before the case is
12 closed.

13 However, that's just -- I'd just make sure that everybody
14 knows where I'm coming from. Once the Board has
15 decided to take a look at these things, I understood
16 that we were going to be looking at cases that were
17 closed. Those are the cases that I'm concerned about.

18 If they are closed, if there has been a decision that
19 was not positive, then I don't want to see our
20 recommendations used to try to provide an avenue to
21 redress the decision. That's where I'm coming from.

22 If we're talking about the internal processes that have been

1 described, then I'm fine, and this language is
2 perfectly fine.

3 **DR. ZIEMER:** They can re-interview now.

4 **DR. ANDRADE:** Go ahead?

5 **DR. ZIEMER:** They can re-interview currently if they need
6 more information. That's not --

7 **DR. ANDRADE:** As many times as they need.

8 **DR. ZIEMER:** -- the issue that's being -- that's not the
9 issue, I don't think. I think the issue was exactly
10 what you described; you want to re-interview a closed
11 case.

12 **DR. ANDRADE:** Right.

13 **DR. ZIEMER:** That was the -- all right, let's go back here -
14 - is it Mark next? Then Jim.

15 **MR. GRIFFON:** Yeah, just a couple of things. I mean I -- I
16 think -- you know, one thing that I've heard in
17 previous meetings from public comment is that there is
18 a concern with the interview and the information that's
19 being collected, so I don't know that we don't have any
20 concerns over it. We've heard that expressed at
21 several meetings. Maybe those things have been
22 corrected. I don't -- you know, that was a while --

1 some of these were a while ago, but you know, to say
2 that we haven't had any concerns over this, I think is
3 not -- is not true. I think we do have some concerns
4 over that.

5 The second thing I was going to ask is if the Department's
6 policy is that re-interviewing is off the table, what -
7 - what's the policy on this -- we -- we did bring up
8 the idea of taping and creating a transcript of the
9 interviews upon the consent of the claimant, obviously.

10 Is that off the table? Can that be -- is that
11 something that the -- the Department would consider? I
12 know it -- there's hurdles involved, but --

13 **MR. ELLIOTT:** We have considered that, and we have
14 articulated the problems associated with that numerous
15 times. And at this juncture, it's -- it's not a viable
16 recourse.

17 **DR. ZIEMER:** Jim?

18 **DR. MELIUS:** Yeah, a few comments -- address some of -- some
19 of these points. First, as Mark said, I mean the
20 interview is a very public part of the program, and we
21 are much more likely to have people concerned about
22 their interview than to ask questions about IMBUS (sic)

1 or how IMBUS is calculated or -- or whatever, what
2 assumptions were used or these other technical
3 information. So it's always going to be very visible,
4 and so I think in -- and people may sort of attribute
5 more importance to it than is appropriate in their
6 individual case or something, and particularly given
7 the time frame involved, the survivor issue and so
8 forth. And so I think we have to have a credible
9 process in place. NIOSH has to have a credible program
10 to review it and then continue to -- continue
11 improvement issue, and then the Board has to have a
12 credible process for -- for reviewing it, so -- read
13 there -- and again, in going through it, we didn't see
14 any particular problems. However, what we did notice
15 was that there were a number of places that NIOSH had -
16 - steps NIOSH had in place that reviewed the interview.
17 They were listening in, there was an initial review,
18 there's a later review. I think the question of are we
19 going to find problem-- potentially find problems with
20 the interview -- probably going to come up -- the issue
21 with -- at the point of the individual dose
22 reconstruction where someone's looking in a lot of

1 detail at all the information on the case and would
2 notice discrepancies, potential problems. Those may
3 very well be dealt with by, you know, a quick check of
4 the record or a quick call back to the person for
5 clarification or something, and that's fine. And all
6 we're asking for here is really that that be reported
7 in some way so we -- so we have a record of it and so
8 forth. So I think that's -- go forward.

9 I think -- yeah, we understand the Department's going to be
10 resistant to re-interviewing and so forth. At the same
11 time, we have an obligation, you know, that Congress
12 gave us to review the dose construction --
13 reconstruction program, and we have to be able to say
14 that we're -- that we as a Board are doing that
15 properly. And if -- and that means we have to be able
16 to say something about the interview program. And we
17 don't want to be put in the position where we're having
18 to say that we could not carry out our assigned mission
19 because we weren't given the capability or the access
20 or tools necessary to -- to review a major part of this
21 program. I think what we've laid out here may get us
22 there, so I think that's --

1 **DR. ZIEMER:** I think that's a good point, Jim. I think the
2 subcommittee (sic), at least from what I heard, felt
3 like if there was in place a good quality assurance
4 program and that that could be audited, in fact we
5 would be able to reach the level of confidence that
6 we're talking about -- a good possibility of reaching
7 that without having to do a re-interview. But these
8 would be key items that would help us get there, and
9 that was the thrust of it, I believe.

10 Okay. Roy again?

11 **DR. DEHART:** No.

12 **DR. ZIEMER:** No. Okay. Gen, Gen Roessler.

13 **DR. ROESSLER:** I'm totally in support of the proposal here
14 and the motion down through number two, but I'm not
15 comfortable with even bringing in the wording about re-
16 interviewing, for the same reasons that Tony has
17 stated. Even though it says we're not going to do it
18 at this time, by bringing in the wording, it leaves it
19 open. And I just think that's inappropriate. I think
20 I would totally support this if we went with Tony's
21 friendly motion or whatever it was, but it --

22 **DR. ZIEMER:** I don't know if Tony actually made the motion.

1 You're certainly free to make the motion if you wish -

2 -

3 **DR. ROESSLER:** I guess what I'm saying is I'm totally for
4 this if we can take out those sentences that include
5 re-interviewing, even though it says we don't recommend
6 it at this time. Just bringing the wording in leaves
7 it open. It leaves it sounding like this is a
8 consideration, and I -- well, maybe if it is later on,
9 it could be brought up later on, but I -- I don't think
10 the wording needs to be in it at this time.

11 **DR. ZIEMER:** And again I'll point out, I don't know if
12 you're making the motion yet or not, whether it's there
13 or not doesn't preclude the Board taking some other
14 action at a later date in any event, whether or not you
15 wanted to.

16 **DR. ROESSLER:** But then I --

17 **DR. ZIEMER:** Are you making a motion to amend by deleting
18 the last two sentences?

19 **DR. ROESSLER:** I could do that. Yeah, I -- I think the
20 point is, whether it's there or not, if we can do it
21 later on, let's just leave it for later on. Let's not
22 even bring in the thoughts at this time. I don't see

1 that it adds anything, and I think it detracts from --

2 **DR. ZIEMER:** So are you speaking in favor of the motion that

3 you haven't yet made, or...

4 **DR. ROESSLER:** I guess I was hoping Tony would make the

5 amendment to the motion. I think he had the wording.

6 **DR. ANDRADE:** I'll let Mike --

7 **DR. ZIEMER:** Okay, we have a comment first from Mike.

8 **MR. GIBSON:** Just on the issue of the re-interview, you

9 know, I don't think we're trying to say that, you know,

10 NIOSH isn't doing the right thing, asking the right

11 questions as they know them. But there could be some

12 things that come up during a site profile that would --

13 could possibly reflect back on the claimant and they

14 would need to re-interview them, too, that wasn't

15 necessarily known to NIOSH at the time.

16 **DR. ZIEMER:** Any further comments? Are there -- does anyone

17 wish to amend this document before we vote on it? If

18 there are no... There appears that -- okay, Tony. I'm

19 not trying to urge you to do it. You can either...

20 **DR. ANDRADE:** I really don't want to have another meeting to

21 discuss all of the intricacies here. Mike brings up a

22 very good point, and there are other concerns on the

1 table. But I think we've had our Federal official
2 advise us about the likelihood of us ever doing
3 retrospective interview after a final decision has been
4 made, and I -- based on that, I think -- not I think, I
5 will make the motion that the only change really --
6 this is a -- this is a very well-done draft here, Jim,
7 that the only change that I would submit for the
8 Board's consideration in a motion to move on this is
9 that we delete the last two sentences of the document
10 and go forth with the rest as a recommendation to
11 NIOSH.

12 **DR. ZIEMER:** Okay. This is a motion to amend the document
13 by deleting the last two sentences. Is it --

14 **DR. ROESSLER:** I second it.

15 **DR. ZIEMER:** Seconded. Now is there discussion on the
16 motion to amend?

17 **DR. MELIUS:** Yeah.

18 **DR. ZIEMER:** Okay, here and then there.

19 **DR. MELIUS:** (Off microphone) Yeah, a couple of points.

20 **MR. ELLIOTT:** Use your mike, please, Jim.

21 **DR. MELIUS:** Sorry, I didn't realize that Gen had borrowed
22 it here.

1 Two things. With all due respect to our Federal official,
2 we are -- our charge is in some ways separate from them
3 and I -- I hate to have us be doing an amendment in
4 reference to having Larry tell us we shouldn't be --
5 what we can and cannot do to review the program we're
6 supposed to be reviewing. I think that raises some
7 issues about our -- our charge. I think -- appreciate
8 what he's telling us factually and -- and so forth and
9 I don't think that's his motive, but I think --
10 (Inaudible) by that.

11 Number two, my understanding of the charge to our working
12 group was to deal with this issue, and in some sense
13 the reference to re-interviewing is because of the way
14 Paul gave us the charge and the discussions we had in
15 order to carry this out. And it was specifically not
16 to design how the program could be reviewed or develop
17 what's the best review of the interview process, but
18 rather were there things that we could do that would be
19 sufficient, short of re-interviewing or some other,
20 more intrusive process that -- to do. And I think -- I
21 think we need to have that reference in there. I don't
22 think it commits us one way or the other and if there's

1 wording that would, you know, add -- you know, re-
2 interviewing or other methods of evaluation, that's
3 fine. But I think we need that reference -- reference
4 in there. You know, I -- quite frankly, I think the
5 committee's split on this issue and -- and it's a hard
6 one to deal with conceptually. I think the way we're
7 taking -- again, aside from those two sentences, the
8 way we're taking is a way of trying to develop a
9 compromise that everybody can live with and -- and then
10 when we get, you know, down the road, whatever it will
11 be a year or two years when we have this information,
12 we'll be able to make a more informed recommendation
13 one way or the other. And maybe our differences will
14 be less at that point in time, but I certainly feel
15 that that's -- this should be -- reference should be
16 kept in there.

17 **DR. ZIEMER:** Okay. So you're speaking against the motion.

18 Okay.

19 **MR. ELLIOTT:** Point of clarification.

20 **DR. ZIEMER:** Point of clarification.

21 **MR. ELLIOTT:** Point of clarification, the charge to the
22 working group was specific in evaluating options or

1 identifying options to evaluate the interview process.

2 **DR. MELIUS:** That's not the way that Paul gave me the
3 charge.

4 **DR. ZIEMER:** Well, I don't recall the exact wording. I can
5 tell you that the Chair's objective is to try to find a
6 way to audit this without doing interviews, but -- but
7 --

8 **MR. ELLIOTT:** I can assure you, that's the exact charge from
9 the transcript. I sent it to the working group the
10 other day.

11 **DR. ZIEMER:** But I -- but I don't -- again, let me point
12 out, it doesn't -- I'm not speaking for or against the
13 motion. I would point out if the sentences are struck,
14 this does not preclude anything. It simply doesn't
15 address it right now.

16 Henry?

17 **DR. ANDERSON:** I guess one -- one argument I would see for
18 leaving it in is it provides some institutional memory
19 that in four years every Board member here could rotate
20 off. In a year we may have --

21 **DR. ZIEMER:** Where did you get the four?

22 **DR. ANDERSON:** Well, the assignments is -- the assignments

1 are one to four years. I rotate off in four months,
2 and there's two others -- we haven't -- it hasn't been
3 discussed here -- are slated to potentially rotate off
4 or at least would have to be renominated, others would
5 be -- potentially could come on, so one of the benefits
6 I see of having this here is we've -- we've spent, I
7 would say, almost an inordinate amount of time
8 discussing it, but it isn't reflected anywhere in any
9 of -- a recommendation or things we've made, so yes,
10 it's there kind of lost and forever of the transcripts.

11 Somebody would have to go back if, when the review
12 comes up four years from now, and somebody says well,
13 let's go back and see what our recommendations -- were
14 they met, this would just remind you well, here's an
15 option that was discussed. So that -- I think it's
16 helpful to have this. It doesn't make a commitment,
17 but as you say, you could go back, but somebody may not
18 even remember about --

19 **DR. ZIEMER:** Let me point out, Henry, where this is going to
20 appear and that is in the transcripts.

21 **DR. ANDERSON:** Well, but -- but if you --

22 **DR. ZIEMER:** The transcripts are there already. That's the

1 institutional memory. This is -- this is no better
2 than the transcripts in which it will appear anyway,
3 one way or the other. The issue has appeared over and
4 over in the transcripts. That's all I'm saying.

5 **DR. ANDERSON:** Yeah, well, I -- I -- I --

6 **DR. ZIEMER:** But -- no, I do point --

7 **DR. ANDERSON:** I'm just saying --

8 **DR. ZIEMER:** I understand --

9 **DR. ANDERSON:** -- on every other board I've been on, what
10 the agency pays attention to and subsequent board
11 members is what are your action items and -- and we've
12 tended not to maintain a list of action items. What we
13 have is resolutions and recommendations that we've
14 made, and one could go back and say --

15 **DR. ZIEMER:** Gotcha.

16 **DR. ANDERSON:** -- as a new member, you'd want to -- you'd --

17 **DR. ZIEMER:** A specific action item.

18 **DR. ANDERSON:** You'd want to know what are the specific
19 issues. That -- you know, I just raise that as one
20 reason for having it here.

21 **DR. ZIEMER:** Okay.

22 **DR. ANDERSON:** It doesn't make a commitment to do it, but to

1 have no mention of it --

2 **DR. ZIEMER:** Okay.

3 **DR. ANDERSON:** -- means somebody has to think of it later
4 down the --

5 **DR. ZIEMER:** You speak for the motion then. Anyone speaking
6 against the motion? Okay.

7 **MR. ESPINOSA:** Against the motion?

8 **DR. ZIEMER:** Well, I'm going to alternate. Against the
9 motion?

10 **MR. ESPINOSA:** Yeah, I'm against the motion. I agree with
11 Henry. I believe that it should be in there. It
12 doesn't matter whether it's left out or put in, either
13 way it does give us something to reference back on, as
14 Henry's saying. So therefore I speak against the
15 motion.

16 **DR. ZIEMER:** Okay. Anyone for the motion?

17 **DR. DEHART:** For the motion?

18 **DR. ZIEMER:** For the motion.

19 **DR. DEHART:** I speak on behalf of the motion, and I'll
20 explain very quickly why. The title is the
21 recommendations of, and the next to the last sentence
22 begins (reading) At this time, the working group is not

1 recommending...

2 We're countering what we're saying in the document. I speak
3 for the motion to delete.

4 **DR. ZIEMER:** Okay. Mark?

5 **MR. GRIFFON:** Yeah, I'm speaking against the motion. I -- I
6 -- and one of the reason-- I mean I've already spoke to
7 some of my concerns about it, I reflect back on a
8 veteran's program review that John Till did and one of
9 the findings that they had was how important the --
10 they weren't even interviews, really, they were -- they
11 were I guess written documents provided by some of the
12 claimants in those cases, and the fact that the dose
13 reconstructors may have underestimated doses in many
14 cases because they didn't incorporate adequately the
15 information that was identified in some of those
16 interviews. So I think -- you know, this is such an
17 important -- I think it's an important component. I
18 think how it's designed is critical to how much
19 information you're going to elicit from these people
20 and how -- how useful it can be. I think it can be
21 very important, though, and I -- I don't want to close
22 the door. In fact, I was hoping that the working group

1 would come out with a recommendation on how to -- to
2 re-interview or tape or -- or to actually have the
3 Board do an audit. I think it's a little soft in that
4 regard, but at least I want the last clause in that
5 allows us -- reminds us that the door is open to re-
6 examine this issue upon findings of the other steps in
7 -- in section one of this document.

8 **DR. ZIEMER:** Just for clarification, Mark, wasn't Till's
9 concern that material elicited in the interviews wasn't
10 in fact utilized, as opposed to the issue of not having
11 adequate interviews? See, I --

12 **MR. GRIFFON:** Well, yeah -- yeah, they didn't have
13 interviews, but the -- yeah. I mean but the -- they
14 said that they weren't -- that they weren't really used
15 by the dose reconstructors adequately and they didn't
16 pay attention to them or --

17 **DR. ZIEMER:** But the issue that we have is sort of a
18 separate issue.

19 **MR. GRIFFON:** It is sort of a separate issue, but it just
20 demonstrates the importance of the tool, is what I'm
21 saying.

22 **DR. ZIEMER:** The interview is definitely important. That's

1 why we're talking about reviewing it. Okay. Wanda has
2 a comment.

3 **MS. MUNN:** I need one point of clarification. We are
4 talking about closed claims. Correct?

5 **DR. ZIEMER:** Closed claims. That's correct.

6 **MS. MUNN:** If we are talking about closed claims, then the
7 consideration of re-interviews puts this Board in the
8 position of being viewed by the public as a quasi-
9 appellate group.

10 **MR. PRESLEY:** That's exactly right.

11 **DR. ANDRADE:** Exactly.

12 **MS. MUNN:** I am not prepared to serve as an appellate. I
13 don't believe that was the charter of this group and I
14 won't go there.

15 **DR. ZIEMER:** Thank you. Further comments? Roy, you have
16 another comment? Robert?

17 **MR. PRESLEY:** Well, early on we were in Cincinnati and some
18 of us witnessed some of the interviews. And I'm going
19 to be honest with you. I'm -- I'm accepting to what
20 they're doing. I think if we go to this, we're getting
21 ourselves in trouble.

22 **DR. ZIEMER:** So you speak for the motion?

1 **MR. PRESLEY:** For the motion.

2 **DR. ZIEMER:** Any other comments, for or against the motion?

3 Are you ready to vote?

4 Okay, those in favor of the motion, raise your right hand.

5 (Affirmative responses)

6 **DR. ZIEMER:** One, two, three, four, five for the motion.

7 Those opposed?

8 (Negative responses)

9 **DR. ZIEMER:** One, two, three, four, five, six opposed. The
10 Chair votes for the motion. We're six and six. The
11 Chair rules that the motion does not pass. It requires
12 a majority to pass. That's not the same as failing,
13 but it doesn't pass. Which means we return to the
14 original document, as written. Okay?

15 Now incidentally, under Robert's Rules, anyone can challenge
16 the Chair's ruling, and the challenge has to be upheld
17 by two-thirds vote, so -- so the ruling is that the
18 motion fails for lack of a majority. It seems like the
19 Chair ought to get two votes in these cases.

20 **DR. ANDERSON:** Actually I thought the Chair didn't vote
21 unless it was a tie, but that's okay.

22 **DR. ZIEMER:** Actually under Robert's Rules, that's generally

1 the case. But I think we agreed in our own rules that
2 the Chair would always vote so that people knew where
3 the Chair stood or didn't stand.

4 So the motion fails and we have before us the original
5 document, as written. Is there any further discussion
6 on the document as written?

7 Are you ready to vote on the document which -- the
8 recommendations and the not recommendations of the --
9 usurping Roy's characterization.

10 A comment, Tony?

11 **DR. ANDRADE:** Just a quick question for you, Paul. As I
12 mentioned, I didn't have a chance to provide my
13 editorial and lesser comments to Jim.

14 **DR. ZIEMER:** Can we do these as friendly amendments? Are
15 they -- are they strictly editorial?

16 **DR. ANDRADE:** They really are.

17 **DR. ZIEMER:** Do you want to --

18 **DR. ANDRADE:** Would it be possible to do that, even if we
19 adopt --

20 **DR. ZIEMER:** Yeah, let's do it real quick.

21 **DR. ANDRADE:** -- the document as written?

22 **DR. ZIEMER:** Just tell us what they are.

1 **DR. ANDRADE:** Okay.

2 **DR. ZIEMER:** We'll see how friendly they are.

3 **DR. ANDRADE:** Okay, on point number 1(a), records of the
4 current -- like I said, this is editorial -- management
5 monitoring instead of supervisory monitoring.

6 **DR. ZIEMER:** Any problem with that, management monitoring?

7 (No responses)

8 **DR. ZIEMER:** So ordered.

9 **DR. ANDRADE:** Okay. On point (b), the second step in the
10 review is not necessarily done by management, but it is
11 done by another group of people that look for accuracy
12 in -- both technical and editorial. And so I'd like to
13 strike the word "management", and also call it the
14 proper -- give it the proper title, and it's review of
15 the -- and it's not completed interview, it's the
16 summary report to...

17 **DR. ZIEMER:** Is this the review that -- where somebody's
18 looking at it for everything from grammar to --

19 **DR. ANDRADE:** Yes.

20 **DR. ZIEMER:** What is the proper terminology we want here?

21 Can on staff help --

22 **MR. ELLIOTT:** He's got it.

1 **DR. ANDRADE:** It is the summary report.

2 **DR. ZIEMER:** It's the summary review, okay.

3 **MR. ELLIOTT:** Summary report.

4 **DR. ANDRADE:** To, and then "include" instead of "including"

5 --

6 **DR. ZIEMER:** The summary review of the completed interviews?

7 **DR. ANDRADE:** Of the summary report --

8 **DR. ZIEMER:** Summary report.

9 **DR. ANDRADE:** Instead of completed interviews, to include --

10 and then here's an insertion, "items that are found to

11 need further clarification" and strike everything up to

12 "and corrective actions".

13 **DR. ZIEMER:** Okay. Let me ask the working group, are you

14 comfortable with this rewording as far as --

15 **DR. MELIUS:** That's fine, yeah.

16 **DR. ZIEMER:** -- it covers the intent still? Thank you.

17 So is it -- let me read what I have and see if it agrees.

18 Records of the summary report of the completed

19 interviews, to include --

20 **DR. ANDRADE:** No, no, no, no.

21 **DR. ZIEMER:** No?

22 **DR. ANDRADE:** These are not completed interviews.

- 1 **DR. ZIEMER:** I'm sorry.
- 2 **DR. ANDRADE:** These are still in review process.
- 3 **DR. ZIEMER:** Read it again. Read it again, I --
- 4 **DR. ANDRADE:** Okay. Records of the review of the summary
5 report, to include items that are found to need further
6 clarification, including corrective actions. So by the
7 word "items" I'm including anything small or large,
8 including significant problems. Okay?
- 9 **DR. ZIEMER:** Okay.
- 10 **DR. ANDRADE:** Item (c), second line there, "dose
11 reconstruction is being done to include any items --
12 instead of "significant problems" -- found --
- 13 **DR. ZIEMER:** That is a slight -- that is probably slightly
14 more than an editorial. It changes the level of
15 findings, but let me ask if the working group considers
16 that a friendly amendment or do you have prob-- it
17 actually requires more reporting than you would have
18 suggested here, I believe. It lowers the bar a bit on
19 what's reported. Working group okay? Chair of the
20 working group?
- 21 **DR. MELIUS:** Yeah, that's fine. That's not...
- 22 **DR. ZIEMER:** Without objection, we'll consider that a

1 friendly amendment.

2 **DR. ANDRADE:** Okay. To continue on with that, "to include
3 any items found" -- and then again an insertion -- "to
4 need further clarification" -- and then we continue
5 with the phrase, "and corrective actions".

6 **DR. ZIEMER:** Ray, did you get all that, as well, for the
7 record? Thank you.

8 **DR. ANDRADE:** The very last editorial comment is in the
9 phrase that falls right underneath -- right underneath
10 (f). And frankly I didn't have a chance to construct
11 it, but I wanted to include the fact that we are having
12 a subcontractor perform part of this review, and I just
13 didn't know exactly where to fit that in there, Paul.

14 **DR. ZIEMER:** Notice that (a) through (f) are things that
15 it's suggested be part of NIOSH's system so that we can
16 review it, so I'm not sure we'd bring our subcontractor
17 into the picture at this point, if I understand what
18 you're saying.

19 **DR. ANDRADE:** Okay. Well, maybe that's appropriate to just
20 leave it off.

21 **DR. ZIEMER:** This is just identifying sort of a body of
22 kinds of records that could be reviewed, I believe.

1 **DR. ANDRADE:** Okay. I'll agree to that.

2 **DR. ZIEMER:** Let me ask again, is the Board comfortable with
3 these friendly amendments to the document?

4 **MR. OWENS:** (Off microphone) On (c) --

5 **MR. ELLIOTT:** Can you speak into the microphone?

6 **MR. OWENS:** Oh, I'm sorry. Tony, on point (c), in the
7 previous (b) we changed completed interviews --

8 **DR. ANDRADE:** Right.

9 **MR. OWENS:** -- to summary report.

10 **DR. ANDRADE:** Right.

11 **MR. OWENS:** And so in (c) are we going to leave completed
12 interviews or are we in essence going to change that to
13 summary report, also, to make it consistent?

14 **DR. ANDRADE:** Good catch, Leon. It should be summary
15 report.

16 **DR. ZIEMER:** Well, let me follow up. What is it that the
17 health physicist is using, the summary or the
18 interview? Is it -- do you know -- can -- who can
19 answer that? One of the staff. Is -- this is saying
20 records of the health physicist's review of the
21 completed interviews at the time dose reconstruction's
22 being done, so what is it the health physicist is using

1 at that point, is the question.

2 **MR. ALLEN:** Paul --

3 **DR. ZIEMER:** Yeah.

4 **MR. ALLEN:** Well, the completed interview we call the
5 summary report of the interview. It's a summary
6 because it's not a transcript. The --

7 **DR. ZIEMER:** So the health physicist is using --

8 **MR. ALLEN:** It's the completed --

9 **DR. ZIEMER:** -- the summary -- the completed summary report.

10 **MR. ALLEN:** Yes, it's the completed one. In item (b) I
11 think it's -- I think the difference is it's kind of a
12 draft at that point. It hasn't been reviewed. It
13 could possibly change for grammar, et cetera. Does
14 that make any sense?

15 **MS. MUNN:** Uh-huh, yeah.

16 **DR. ANDRADE:** Yeah, it's a little confusing, but --

17 **MR. ALLEN:** Yes, it is.

18 **DR. ANDRADE:** -- recall that the health physicist himself
19 can review this first report that comes down to him,
20 which is still basically a summary report, and still
21 ask for more information and really actually ask for a
22 re-interview if necessary.

1 **MR. ALLEN:** Right, but the difference at this point is (b)
2 is before the claimant ever sees it. After that
3 review, then it goes to the claimant, the claimant can
4 make any changes he wants to. In (c) the claimant's
5 already seen it, has made any changes they want to, and
6 the dose reconstructionist is the one looking at it.

7 **DR. ANDRADE:** So if the health physicist -- if the health
8 physicist has a question and say brings up a small
9 technical point that needs to be clarified, and that
10 may require an interview again or may need some
11 clarification from other people that have listened in,
12 then what is it called?

13 **MR. ALLEN:** At that point, if we were to call the claimant
14 back again or get a letter or whatever from the
15 claimant to change anything, we change it and it's an
16 updated summary report, is what we call it.

17 **DR. ZIEMER:** But for practical purposes, it's the completed
18 summary report --

19 **MR. ALLEN:** Completed summary --

20 **DR. ZIEMER:** -- or completed interview report. Is that the
21 same as --

22 **MR. ALLEN:** Yeah, there's very little -- the semantics

1 aren't too --

2 **DR. ZIEMER:** I think we understand it then.

3 **MR. OWENS:** And I didn't intend to do anything --

4 **MR. ALLEN:** In any case we'll get the right seman-- the
5 right titles --

6 **DR. ZIEMER:** We'd better vote before... Are you now ready
7 to vote? And because of the previous vote, you
8 recognize -- and I'm recommending that those who voted
9 for the prior motion not vote against the document
10 because of the presence of the last two sentences,
11 recognizing that the record will indicate that there
12 was a sort of split on the issue of the last two
13 sentences, but the rest of the document perhaps could -
14 - not that the Chair's trying to influence anybody, but
15 we -- we don't want to throw everything out, if
16 possible. We need the rest of the document, so --

17 **MR. PRESLEY:** Clarification?

18 **DR. ZIEMER:** Yeah.

19 **MR. PRESLEY:** Last paragraph, third line, "At this time the
20 working group", should we not change the working group
21 to Board?

22 **DR. ZIEMER:** That's a good point. I think a friendly

1 amendment here needs to be made. Does the subcommittee
2 (sic) agree? It now is a recommendation of the Board,
3 not the subcommittee.

4 **MR. ELLIOTT:** And also up in the first sentence.

5 **DR. MELIUS:** And the first sentence should read the same,
6 too.

7 **MR. PRESLEY:** Yes.

8 **DR. ZIEMER:** Thank you.

9 **MR. PRESLEY:** Yes, I...

10 **DR. ZIEMER:** Ray, that's the first sentence in the document
11 will read -- instead of working group, Advisory Board
12 on Radiation and Worker Health, and then the third line
13 of the last paragraph, instead of working group will
14 read Advisory Board on Radiation and Worker Health.

15 Now are we ready to vote? All those who support the
16 document, please say aye.

17 (Affirmative responses)

18 **DR. ZIEMER:** Those opposed, no?

19 (No responses)

20 **DR. ZIEMER:** Any abstentions?

21 (No responses)

22 **DR. ZIEMER:** The motion carries. Thank you very much.

- 1 **MR. ELLIOTT:** I'd like to thank the working group for their
2 efforts on this.
- 3 **DR. ZIEMER:** Appreciate it. Okay, we're a little over time
4 for the break. Let's go ahead and take the break.
5 Break till about 3:00, if that's agreeable.
- 6 Let me also ask -- is Cori here? Do we have anyone signed
7 up for public comment for this afternoon and how many
8 individuals? Two individuals? If the individuals -- I
9 want to ask if the individuals -- the public comment
10 period is scheduled for 2:45. We can -- we can go
11 ahead with that now or we can take the break. It
12 depends on whether those individuals need to leave or
13 would just as soon have the break themselves right now.
- 14 **DR. MELIUS:** Let's break and...
- 15 **DR. ZIEMER:** Patricia Ehlmann and Knute Ringin -- is it
16 Ringin? Patricia, are you all right if we go at 3:00
17 instead of 2:45?
- 18 **MS. EHLMANN:** (Off microphone) That's fine.
- 19 **DR. ZIEMER:** All right. And Knute -- is it Knute?
- 20 **MR. RINGIN:** (Off microphone) It's Knute.
- 21 **DR. ZIEMER:** Is that -- is that okay?
- 22 **MR. RINGIN:** (Off microphone) Sure.

1 **DR. ZIEMER:** Okay. Then we'll take a 15-minute break.

2 Thank you.

3 (Whereupon, a recess was taken.)

4 **PUBLIC COMMENT PERIOD**

5 **DR. ZIEMER:** We're going to reconvene and proceed with the
6 public comment period.

7 We're going to begin with Patricia Erlmann -- do I pronounce
8 that correctly?

9 **MS. EHLMANN:** Ehlmann.

10 **DR. ZIEMER:** Ehlmann.

11 **MS. EHLMANN:** It's German.

12 **DR. ZIEMER:** It's a Deutsche name. She's from Wright City,
13 Missouri, which is in the St. Louis area, was not able
14 to be with the Board when we were in St. Louis, but
15 we're pleased that she's able to be here today.
16 Patricia, we'll -- if you will use the podium here --
17 or okay, the mike there is on, that's fine. Thank you.

18 (Pause)

19 **DR. ZIEMER:** Okay, thank you for your patience. Patricia,
20 please proceed.

21 **MS. EHLMANN:** I just want to say that my name's Patricia
22 Ehlmann, and my brother and I are survivor claimants

1 for Everett Powers, tracking number 10141, case number
2 21496, file number 488092991. My dad was employed at
3 Mallinckrodt from the 4th month of 1943 to the 10th
4 month of 1966. He started at the St. Louis plant and
5 was transferred to Weldon Springs around 1957 when the
6 plant opened. He was diagnosed with multiple myeloma
7 in 1983. His cancer was chemo-resistant, although he
8 did have to go through a lot of chemo treatments.

9 This type of cancer attacks the bone marrow, so his bones
10 disintegrated to the point of vertebrae fractures,
11 which were extremely painful. During all of this
12 treatment he also had at least two chemical peels of
13 his head. As you can see from his picture, he was very
14 bald, so he had a lot of skin to come off the top of
15 his head.

16 This is a terrible ordeal to go through for skin cancers.
17 Squamous cell cancer took part of his nose, most of one
18 nostril and approximately one-half of his lips. Due to
19 the weakness of bone disintegration, he fell one
20 morning getting out of bed -- and this was on a
21 carpeted floor -- causing a brain hemorrhage for which
22 he had brain surgery. So now he had three holes bored

1 in his head. And since this is basically a stroke, he
2 had to completely go through therapy to regain speech,
3 movement of his arm and his hand.

4 My dad smiled all the time, and right up to the time the
5 morphine completely knocked him out, he was smiling.
6 He died in September of 1987. My mother filed the
7 first claim in 2001 and at her passing in September of
8 2002, my brother and I sent in claims.

9 We're just normal people who know very little about
10 government paperwork, and boy, were we in for a shock.

11 After finally finding everything we could, with a lot
12 of help from Paducah, we were in for another problem.
13 The paperwork showed -- proved to the DOL all of the
14 cancers that I listed above, but it only showed that he
15 worked at the Weldon Spring plant. After many phone
16 calls, with the help of Denise Brock, I finally had a
17 conference call between myself, Ms. Brock and Jeremy
18 Stanton of the DOL. He stated that their paperwork
19 showed that he only worked at Destin (sic) in St.
20 Louis. Now I mean this is getting crazy. I've got the
21 same Department telling me he worked in two different
22 places. We need help to resolve this. We're not the

1 have to do your request over.

2 **MR. RINGIN:** Well, I'll try to keep it a little bit shorter.

3 As I said, my name is Knute Ringin and I'm glad to be
4 here. I've not bothered you at previous meetings, but
5 I think I have enough to talk about now that it's
6 worthwhile to take a little bit of your time.

7 I am the science advisor to the Center to Protect Workers
8 Rights. CPWR is a non-profit research and development
9 arm of the National Building Trades department of the
10 AFL/CIO. Since I'm going to talk about ethics a little
11 later, I would like to make a couple of disclosures to
12 begin with.

13 First of all, CPWR has a very large, significant and
14 longstanding partnership with NIOSH in the area of
15 construction safety and health. We also have a
16 contract with OCAS to try to develop better dose and
17 radiation monitoring estimates for construction
18 workers. We're responsible for -- involved in medical
19 screening programs for construction workers at Hanford,
20 Savannah River, Oak Ridge, Portsmouth, Paducah and
21 Amchitka. And in the course of the last six years,
22 we've probably interviewed more than 10,000 workers in

1 those sites.

2 We also have a contract that DOL just asked us to take on to
3 help them establish employment verification where DOE
4 cannot verify that a worker has been employed at a DOE
5 site. For construction workers, that's close to 20
6 percent. That's 20 percent where DOE does not have
7 employment history, let alone radiation dose monitoring
8 history.

9 Now I'm not an expert on radiation, and I don't come here to
10 talk to you really about radiation, radiation
11 monitoring or radiation biology. My comments are
12 specifically limited to construction workers, which we
13 represent and which I know something about, and to the
14 claimants who are construction workers. My comments
15 may or may not be relevant for other types of
16 claimants, but they're relevant for those workers who
17 come as construction workers and who have some unique
18 characteristics.

19 The first is, they're all employed intermittently at DOE
20 facilities. The second is that they're working largely
21 in uncharacterized or inadequately-characterized
22 environments. And the third is that they work under

1 uncontrolled working conditions with little or no
2 supervision most of the time.

3 Now these workers happen to have a large stake in your
4 program that you're reviewing. There've been many more
5 construction workers at DOE facilities than production
6 workers, which most people don't realize. For
7 instance, at Hanford we estimate there are 59,000
8 construction workers at risk for radiation exposure;
9 37,000 at Savannah River; more than 30,000 at Oak
10 Ridge. And roughly half of the current claimants in
11 your program are construction workers or their
12 survivors, so it's not going to be an incidental issue
13 to your deliberations.

14 We're grateful that NIOSH is finally starting to process
15 cases. It's obviously long overdue. We're deeply
16 concerned about that because we hear it from our
17 members all the time. But the 1,000 cases processed so
18 far cannot be used to est-- make any kind of
19 determination or estimate about what this program is,
20 should or will do in the future. So far what you've
21 seen are the easy, the straightforward cases mostly;
22 the ones who are obviously yes or obviously no and that

1 have been processed pretty fast. What I'm concerned
2 about is the 30 or 40 percent of our members where
3 there are no valid dose data and where claimants have
4 difficulty recalling their work history for you, and
5 that's a large number of them.

6 Let me also say from the start that we did not agree with
7 NIOSH's interpretation of the law and its plans for
8 dose reconstructions, and we've had many discussions
9 with the NIOSH management about that, with Larry and so
10 on. We didn't think that this approach was going to
11 work for our members, and so far we don't see much
12 evidence that it is. The problems that we look at here
13 can be traced to two fundamental flaws in the way that
14 I think the program has been set up.

15 For claimants like ours who have problems with dose
16 information, the original dose reconstruction rule
17 under which the program operates is extremely lacking
18 in specification. It's fairly specific when it comes
19 to dealing with workers who have dose, and then it has
20 two very general paragraphs dealing with workers who
21 don't have dose, where they say we may either
22 extrapolate from workers similarly situated, or we may

1 use some other kinds of environmental data. That's
2 essentially all the dose reconstruction rule says. And
3 it doesn't give us enough specificity to determine with
4 accuracy two major effects.

5 Because we don't have defined benchmarks, it's difficult --
6 maybe even impossible -- to make an objective
7 determination about the completeness of the dose
8 reconstruction once it's done. I don't know what we
9 would compare it against for these workers. And
10 secondly, it ends up placing what I think is an
11 unreasonable burden on the claimants to document their
12 exposures and to verify the completeness of the dose
13 reconstruction once it's done. These workers need
14 help, and I'll get back to that.

15 And the second very big flaw in the program that you all are
16 very aware of is that the administrative structure now
17 is so rife with potential for conflict of interest that
18 it's at this point eroded to a great extent the
19 confidence in NIOSH's objectivity, particularly
20 confidence among our claimants, our members who are
21 claimants. And we hear it every day.

22 And it comes largely from two -- there are two effects that

1 arise from this structure. Even though policies and
2 procedures to prevent conflicts of interest have been
3 developed, we're already seeing evidence that they're
4 not adequate -- at least I think we're seeing that.
5 And as a result of this, as I said, NIOSH has a low
6 level of credibility among claimants that it definitely
7 has to overcome. And I think the role of this Board is
8 incredibly important to establish credibility for this
9 program. That's why we have this review. And not just
10 to review what is being done, but to review it in such
11 a way that you re-establish credibility in the program
12 as it goes forward.

13 I want to put this in context by using the Savannah River
14 Site history profile as an example. My comments will
15 reflect a meeting that we had in August on November 11
16 where Jim Neton and four contractors came to review the
17 site profile document with local unions, and we
18 appreciate that he came there on a Federal holiday,
19 which was the only time when we could get everybody
20 together. And everybody that was -- there were 18
21 local union leaders, the leaders of every union that
22 represents workers at Savannah River. We also had a

1 dozen or so workers who spanned the entire history of
2 the Savannah River Site, who had spent considerable
3 time there, to talk about their experience. And we had
4 three technical experts. In addition to myself we had
5 Jim Platner* who is a Ph.D. radiation biologist and Don
6 Ellisberg who's a lawyer with great knowledge about
7 workers comp and who was in charge of all of the
8 Workers Compensation programs at the Department of
9 Labor in the past. So we provided this kind of
10 expertise and we had a very good meeting with Jim Neton
11 and his staff.

12 In fact, I would say that's by far the best meeting that
13 we've had with NIOSH on this program because it was a
14 very open give or take where they said this is what
15 we've done; do you think it's adequate, is it going to
16 work for your members and what can we do better, and we
17 talked about some of those things. And I'm going to
18 talk to you -- show you a little bit about what we told
19 them so that you understand why it's important to look
20 more carefully at these documents.

21 I appreciate the complexity of trying to characterize 50
22 years of production at Savannah River in a short

1 document. Anybody who's been at the Savannah River
2 Site or Hanford or Oak Ridge or INEEL will know that
3 these are incredibly complicated sites, and here we
4 have a document where the text is basically 100 or so
5 pages and a bunch of appendices attached to that that's
6 supposed to somehow explain everything that's happened
7 in terms of radiation to those workers who were there.

8 That's a monumental task and a very difficult one and
9 a very important one.

10 Yet in the end of this, we still have to ask this very basic
11 question. The document that comes out, which ends up
12 being a summary, a distillation of all kinds of stuff,
13 does it end up being fair to the claimants. Is this a
14 document fair to all of the claimants, given that there
15 all kinds of different classes of claimants who have
16 been workers who it's supposed to cover.

17 I don't know if it's fair to ask you all, but how many of
18 you have read the Savannah River site profile document?

19 Yes, I don't blame you if you haven't. It's not easy
20 reading. It's a very dense and complicated document
21 that at least it's taken me a long time to get through.

22 And now we have many more of these things to go

1 through, and I'll get back to why that's also at issue.
2 The Savannah River Site history was issued in the summer of
3 -- during summer of 2003, but we didn't know it until
4 actually your meeting in August, I believe, when it was
5 announced. We were not aware that it was being
6 developed or that it had been issued. And although we
7 can't be completely sure of this since we don't have
8 quite an accurate or at least consistent description of
9 what it's going to be used for, we think this is
10 probably a very important document, that all of these
11 site profile documents are probably very important.
12 Our impression is that it's been developed pursuant to
13 the dose reconstruction rule with a purpose of, to
14 quote the document itself, "to evaluate both internal
15 and external dosimetry data for unmonitored and
16 monitored workers" -- sounds like pretty much
17 everybody, I guess -- "and to serve as a supplement to
18 or substitute for individual monitoring data". That's
19 a very large charge to this document, not very
20 specific, and we'll only learn how it'll be used as it
21 gets implemented.
22 When we reviewed this document we became very concerned for

1 five basic reasons. There really isn't a methodology
2 in this document. If we were to try to reconstruct
3 this document, we would not be able to do so
4 accurately, I don't think. I don't think we'd come up
5 with the same result. And if there's any basic issue
6 in science, it has to be replicability. In order to
7 get to replicability, you've got to have a method and
8 you've got to have documentation that you can follow,
9 and that documentation and method is not sufficient to
10 do that.

11 The report doesn't describe the methods or documentation
12 adequately. And as I said, as a result of this, it's
13 not possible -- I don't think -- to replicate it. But
14 we know it was done by an ORAU contractor team that
15 talked and spent lots of hours with site personnel at
16 Savannah River and used largely internal documents from
17 the Savannah River Site, without specifying necessarily
18 why, whom or when they talked to these people. So we
19 don't have the documentation about exactly what was
20 done. And that doesn't give us a lot of comfort in the
21 process.

22 For instance, the contractor has developed a methodology for

1 extrapolating maximum dose from source terms, and
2 that's used to estimate exposure from the airborne and
3 resuspended I guess exposures. This methodology is
4 listed in the bibliography, but it's only listed as an
5 unpublished document that was prepared by the
6 contractor for the purpose of doing this project. So
7 until one has that document and reviews it, you can't
8 understand what's been done in the report itself. It
9 becomes a little bit of a house of cards.

10 There seems to be some significant omissions, as near as we
11 can tell. Now we based our review on this on a very
12 large site history inventory that we've developed at
13 the University of Cincinnati, and Dr. Eula Bingham has
14 that, as well as approximately 2,000 interviews with
15 workers -- construction workers who have been at
16 Savannah River, and here is what we found that's
17 significant.

18 We found that we have 83 significant site history documents
19 that are not in -- referenced in this document and I
20 don't think have been used. Secondly, we looked at one
21 specific area, which is the area that's common to all
22 of the reactors used at Savannah River and there NIOSH

1 lists that there are 32 core radionuclides, yet we have
2 identified at least ten additional radionuclides. And
3 if you're looking for source terms to extrapolate from,
4 then I think it's important to include all of those.
5 Maybe we missed something, I don't know, but that's
6 what we think is there.

7 There's virtually no description of deficiencies in
8 radiation monitoring programs. If you read this
9 document, you would think that radiation monitoring at
10 Savannah River had been just about perfect from the
11 start. That's not what our workers, our members, tell
12 us in the interviews that we have done and that we can
13 document. There was extensive testimony also on
14 problems in monitoring practices when DOE held town
15 meetings in Aiken in 1999 in development of this
16 program, and that's not at all referenced, or I don't
17 think has been reviewed in the process of developing
18 this document. Also the tiger teams that did their
19 investigations of Savannah River in 1990 documented
20 very extensive deficiencies in monitoring practices,
21 and they're not listed.

22 There is no consideration of radiation incidents or

1 accidents, as near as I could tell. We've identified
2 approximately 76 accidents over the history of the site
3 that we do not see referenced in this report, and that
4 I believe are important if you're going to look at
5 exposures.

6 Throughout the document there is no apparent awareness that
7 construction workers may have very different exposure
8 patterns from production workers. For instance, in
9 applying the model for extrapolation from source term
10 to resuspended radiation, there is no consideration of
11 something as simple as digging in the dirt. Somehow
12 it's assumed that that dirt's not going to be disturbed
13 very much. I don't know where -- how these resuspended
14 -- this resuspended radiation is going to become
15 airborne again, but there certainly isn't taken into
16 account that it might be a source of exposure for
17 people who dig in it, which just about all construction
18 workers do from time to time on these sites.

19 The third concern that we have is one that we take very
20 seriously, and I'm sure you do, and I don't like it.
21 There is a guy named Dr. Eugene Rollins who's listed on
22 the ORAU web site as the key -- as a key person working

1 on this report. He apparently also developed the model
2 to estimate maximum dose from source terms, an
3 important internal report that is referenced
4 extensively in the document itself. According to his
5 conflict of interest statement that's also listed on
6 the ORAU site, it says that he previously worked at
7 Savannah River, including six years in human health
8 risk assessment and one year as a shift supervisor in
9 health physics and radiation monitoring. Now I'm not
10 saying that that leads to a conflict of interest by
11 itself, but I believe according to the policies on
12 conflict of interest, people who have worked on sites
13 should not be working in these documents, and that's at
14 least what the folks who came down to Savannah River
15 told us, that was their intent. So that's something
16 that has to be looked at very carefully because it gets
17 at the heart of this credibility problem.

18 The fourth concern we have is a minor one, but it's
19 technically important, and that is that we think
20 there's a conflict with the dose reconstruction rule in
21 this document. There's a small throw-away thing in
22 there somewhere about a curious minor adjustment to

1 dose for claimants who eat wild game taken in the
2 Savannah River area. Now I don't know what the
3 implications are of this adjustment, but I do know
4 this: According to the dose reconstruction rule, it
5 allows for only one adjustment to dose -- we've talked
6 about this many times -- and that's for smoking in lung
7 cancer. NIOSH agreed from the start that it would not
8 make any of the adjustments, for instance, that NCI
9 suggested for diet and that has been used in some of
10 the other radiation reconstruction programs. And I
11 believe that's included -- at least it's an intent of
12 the dose reconstruction rule that that should not be
13 included, yet there is a conflict here that I think is
14 a technicality, but that could be important. That is
15 that if a document is to be developed pursuant to the
16 dose reconstruction rule, then it should follow the
17 rule itself.

18 Finally, there is no independent review of these documents,
19 as far as I know. Before this document was put on the
20 web and issued for use, there was no review of the
21 underlying methodology, and in this case the
22 unpublished source terms extrapolation method, and

1 there was no independent review of the document itself.
2 Now follow our meeting with the folks in August with NIOSH,
3 we agreed to make available to NIOSH all the
4 documentation that we have, and we would have done that
5 a long time ago had they asked us. I don't know why
6 they didn't come to us when they were developing the
7 report, and it seems that this is particularly serious
8 given that they obviously didn't hesitate to meet with
9 the DOE site personnel. The one-sidedness of this kind
10 of contact does nothing to dispel the sense held
11 broadly that NIOSH is not particularly aboveboard in
12 its work.

13 Now we have good reason at Savannah River to be concerned
14 when you just deal with stuff that the site
15 administration gives you. When we started our medical
16 monitoring program at Savannah River, the site strongly
17 objected to us testing people for beryllium exposure.
18 They said there had absolutely never been any beryllium
19 used at that site, and they said the same thing to
20 NIOSH. After having tested some 2,000 people or so
21 down there, we have about one and a half percent of the
22 workers who have been there testing positive on DOE's

1 recommended beryllium test. And upon those initial
2 findings, the site administration finally 'fessed up
3 and said yeah, there may have been a little beryllium
4 here after all. So it's not comforting to say that
5 it's enough to go to the site administration and ask
6 what kind of documentation do you have; just give us
7 your stuff or tell us what you've been doing and we'll
8 make use of that. I'm not very comfortable with it.
9 Finally, let me also make a point about our claimants that
10 I've made many times before. After the site -- NIOSH
11 placed the site profile document on its web site, it
12 invited comment on it, which one can discover by
13 reading the web site. Apart from this being after the
14 horse left the barn, so to speak -- the document had
15 already been issued -- it clearly places the burden on
16 the claimants to show that there are deficiencies in
17 this document. And that points to me to what seems to
18 be a very unfair balancing act. On the one hand we
19 have the site profile reports. These are very complex
20 documents, presumably with far-reaching significance,
21 presented very much or pretty much as final by NIOSH
22 when it puts it on the web site. NIOSH has major in-

1 house expertise, vast resources through its
2 subcontracts and so on, to put into the preparation of
3 this thing. On the other side are the claimants. Now
4 these are, by definition, either workers with cancer or
5 their survivors. They're mostly old and frail, and
6 they have no support. And they're expected to
7 challenge these documents and to say hey, we don't
8 think there's -- there are problems with this dose
9 recon-- or with this site profile that you've done.
10 That's an unreasonable burden to place on them, because
11 if they don't challenge it right now, NIOSH will do
12 nothing to change these documents.

13 This is not the only burden (sic) where NIOSH places an
14 undue burden on claimants. You talked about the
15 interviews earlier today, and I can safely say that our
16 members tell us that they have trouble following the
17 interviews that are done by phone, and many of the
18 NIOSH interviewers have said the same thing. It's
19 unreasonable to expect these old construction workers
20 to recall a lifetime of information about radiation
21 exposure. But much more difficult are the interviews
22 with survivors, and they're close to half of the

1 claimants here. I believe that the NIOSH interviewers
2 agree that they get very little or nothing out of most
3 of the interviews that they do with survivors.

4 Based on this, I would ask this Board to do three things, or
5 consider doing three things. One is to recommend NIOSH
6 that it issues a replicable method for the preparation
7 of the site profiles, and that this includes validation
8 of the information that it receives from the sites,
9 validation both in terms of the accuracy of what it
10 receives and whether it's complete.

11 Secondly, recommend or require that independent review of
12 these site profiles be conducted before they're issued
13 -- and I was going to call this peer review, but I'm
14 not comfortable with that term in this context because
15 peer review might simply mean a health physics review,
16 and I think there's something much more important.
17 It's not just understanding health physics, but it's
18 also understanding how it applies to workers as they do
19 their work on these sites.

20 And thirdly, I would encourage NIOSH to provide claimants
21 who want it or need it with much more independent
22 assistance with their interactions with NIOSH. NIOSH

1 wants to be claimant-friendly. The site profile
2 document uses this word extensively. But it fails to
3 provide the weakest of claimants what they most need,
4 which is an independent, knowledgeable and forceful
5 advocate in the process of doing all of this work, and
6 it's certainly something that we would like to work on.
7 And in addition, if I may be so bold, once you hold these
8 meetings in the future, I suggest that you make two
9 minor changes, particularly when you're planning to
10 hold your meetings in the tri-cities and in Augusta.
11 First send out a notice to all the claimants who live
12 in that general vicinity, say within a radius of 50 or
13 80 miles or something like that, informing them that
14 you're going to hold this meeting. We will certainly
15 be glad to notify everybody in our programs about it.
16 And in addition, hold an evening session for public
17 comment, maybe on the first day of the meeting, because
18 most people will not come to a day meeting for two very
19 significant reasons. Either they're very old or frail
20 claimants -- whether they're the workers or their
21 survivors -- and they usually need help to come to
22 meetings and they rely on their kids or something like

1 that, and those kids are working. Or they're
2 survivors, who usually are also working, they're the
3 children and is the one who have jobs themselves and
4 can't get away during the day, so maybe a two-hour
5 evening session would be, I think, very enlightening to
6 you. At least if you come to Hanford. I'm sure you'll
7 get an earful.

8 And with that, I thank you for your time and your attention.

9 **DR. ZIEMER:** Thank you, Knute. Let me ask if any of the
10 Board members have questions they may wish to address
11 to you before you leave the podium. Any points of
12 clarification? Henry?

13 **DR. ANDERSON:** Yeah, what -- what kind of follow-up have you
14 had from NIOSH after your meeting in Augusta --

15 **MR. RINGIN:** Well --

16 **DR. ANDERSON:** -- (Inaudible) made your other
17 recommendations as --

18 **DR. ANDERSON:** -- Larry called us about a week afterwards
19 and we had a conversation where he asked us to submit
20 all of our information and documentation, which we were
21 planning to do anyway, and which we've started doing
22 earlier than we had planned to do it so that we're

1 providing them information initially on Hanford,
2 Savannah River, Amchitka in Alaska and the Nevada Test
3 Site and Oak Ridge, and that includes all of the
4 information that we have in our site history
5 repository, as well as all of the results that we have
6 from the -- from the interviews with workers.

7 I can also say to you that doing interviews with workers,
8 particularly construction workers, is very difficult.
9 It took us a long time to learn how to do it, even
10 though we're kind of specialists on construction
11 workers, that unless you put it in terms that they're
12 used to, occupational terms -- you know, the kind of
13 tasks that they do and that kind of stuff -- we don't
14 typically get very far with it. If you put it in terms
15 that they understand -- we use retired construction
16 workers to do those interviews for that reason -- then
17 we get a lot of information.

18 **DR. ZIEMER:** Thank you. Other -- here's another question,
19 Rich Espinosa.

20 **MR. ESPINOSA:** You had mentioned 20 percent of the
21 construction workers that are claimants haven't been
22 able to verify employment. How is...

1 **MR. RINGIN:** When the Labor Department gets a claim, it
2 sends it -- along with a form called the EE-5 form --
3 to the local Department of Energy site where the worker
4 has been working. Our in our -- for our workers, you
5 know, there are many different sites. The DOE facility
6 is then supposed to establish whether or not they have
7 records indicating that this person was an employee on
8 their site. For construction workers, in about 20
9 percent of the claims that DOE site that they send that
10 record to is unable to verify in its documentation --
11 one of the problems is that a lot of our members have
12 been employed by subcontractors and sub-sub tiers of
13 contractors, and it becomes -- having records. Now
14 there should be records somewhere. It's -- you know,
15 you're required to submit certified payroll records
16 every week or month on all of these workers, so
17 somewhere it should be, but they are unable to come up
18 with it in a timely fashion.

19 **DR. ZIEMER:** Thank you. Other questions?

20 **MR. ESPINOSA:** I got...

21 **DR. ZIEMER:** Oh, a follow-up. Okay.

22 **MR. ESPINOSA:** One of the things that concerns me,

1 especially when it comes to the SEC, is the co-worker
2 data, such as if they didn't have enough data for me,
3 they're going to use a co-worker. You mentioned some
4 stuff on service workers and construction workers where
5 they're coming out with two different -- quite -- quite
6 a bit difference in their dose reconstructions. Can
7 you go a little bit further on that, please?

8 **MR. RINGIN:** I'm glad you bring up -- actually didn't think
9 I'd prompted you to ask these questions, but I had --
10 the question about extrapolating from co-workers to co-
11 worker is very, very difficult for construction
12 workers. We've been spending years trying to come up
13 with predictable models for exposures for workers doing
14 similar kinds of tasks. Bob Herrick* -- who many of
15 you know at Harvard -- has worked with us in a working
16 group, and we spent I think two years doing -- just
17 reviewing workers who were doing turnkey maintenance
18 construction on cold-fired utility boilers, thinking
19 that that is a very similar kind of exposure. And we
20 went in there, he did measurements on a lot of these
21 different sites, and all we got was a variance that was
22 so great that we couldn't draw conclusions from it. So

1 we couldn't come up with a statistically predictable
2 model for -- for exposures. And my guess is that
3 that's going to be somewhat similar for radiation.

4 I can also comment a little bit -- unless I'm over-extending
5 my time here -- one of the problems of the way that DOE
6 had characterized its work sites, and I think that the
7 beryllium example is a good one, both for Hanford and
8 for Savannah River. The belief was that construction
9 workers wouldn't have been exposed to beryllium because
10 construction workers don't work with beryllium. And
11 DOE had characterized the environments where beryllium
12 may have been. They'd done wipe samples and that kind
13 of stuff. But after we got all these results on -- at
14 Hanford, for instance, three to four percent of the
15 workers testing positive on the beryllium lymphocyte
16 proliferation test, we started to go back and look at
17 how they had been sampling and estimating environment.

18 And in those buildings they did the wipe sampling up
19 to eight feet on the -- on the walls. They'd not done
20 sampling in the rafters, not above ceiling tiles, not
21 behind wall panels or in subflooring or crawl spaces.
22 Well, that's where most construction workers do their

1 work. Most construction workers don't do new
2 construction. Just about all the construction work
3 that's done now is either repair, maintenance,
4 renovation, demolition or decontamination, and that's
5 where they probably get most of these exposures. And
6 they're exposures that are very hard to predict because
7 the environment isn't anticipated and the work that
8 they're doing isn't anticipated. I don't know if that
9 answered your question --

10 **MR. ESPINOSA:** Yeah, that answered my question.

11 **DR. ZIEMER:** Thank you. Other questions or comments? Thank
12 you, Knute, for your input to the Board.

13 We've come to the completion of today's agenda. We begin
14 tomorrow morning again at 8:00 o'clock in terms of the
15 informal time together, and then the official business
16 beginning at 8:30.

17 Let me pause and see if we have any housekeeping items,
18 Cori, tonight to address? No.

19 **MS. HOMER:** The only thing I would suggest is that if you
20 have anything in the room, take it with you.

21 **DR. ZIEMER:** Okay. Don't leave things in this room over --
22 overnight. They're -- they will become part of David

1 Brenner's comedy act.

2 With that, we'll recess till tomorrow morning. Thank you
3 very much.

4 (Whereupon, an adjournment was taken to Wednesday, December
5 10, 2003 at 8:00 a.m.)
6
7

8 **DECEMBER 10, 2003**
9

10 **P R O C E E D I N G S**

11 **REGISTRATION AND WELCOME**

12 **DR. ZIEMER:** Good morning, everyone. Again I'll call the
13 meeting back to order, the second session of the
14 nineteenth meeting of the Advisory Board on Radiation
15 and Worker Health. Again I remind you if you have not
16 registered your attendance at this meeting, please do
17 so at the -- the books are out on the table at the
18 entryway. Also, members of the public who wish to
19 address the Board, please sign up in the sign-up book
20 that also is at the entryway.

21 Again remind everyone that there are other documents and
22 handouts on the table here to my left. Please avail

1 yourselves of those, as you might find it helpful.
2 Many of you are aware -- perhaps all of you are aware --
3 that the Board has been seeking contract support for
4 assistance in auditing the dose reconstruction process
5 and related matters. The firm that was the successful
6 bidder was Sanford Cohen & Associates, and from that
7 company we have this morning with us Dr. John Mauro,
8 who's going to give us a general briefing about their
9 company.

10 I want to point out both to those here on the -- at the
11 podium or -- in other words, the Board members as well
12 as those in the audience, that this presentation and
13 discussion this morning is very general. The Board has
14 yet to review in closed session the document which is
15 proprietary which will be addressed this afternoon, the
16 task orders and the independent government cost
17 estimate for that support, so the Board will be looking
18 at that in detail this afternoon. But basically this
19 morning we're introducing John and the company to the
20 Board and to the public. So John, we're pleased to
21 have you here this morning, and if you would give us an
22 overview of your organization and related matters.

1 Question?

2 **MR. GRIFFON:** Just a question before we start. Is -- can we
3 discuss or ask John questions regarding the technical
4 skill proposal or --

5 **DR. ZIEMER:** I'm going to ask Martha to address that. My
6 understanding now is that in fact that is still
7 restricted information until the Board has discussed
8 the proposal, so that that may be off-bounds. But
9 we'll ask Martha -- if you would, Martha -- to address
10 that for us and give us a legal opinion here.

11 **MS. DIMUZIO:** We did speak with contracts about this, and
12 basically what we have is we have a document that's
13 before the government for its consideration, so it's
14 not really a public document until a final award has
15 been made. So when Dr. Mauro is giving his
16 presentation, you can ask general questions about
17 anything, but we cannot have any specific discussions
18 about the proposal that he's submitted or the
19 approaches that SC&A may be taking in -- in their
20 approach to completing those tasks. That's really
21 discussion for this afternoon in the closed session.
22 It's a -- the document is not a public document at this

1 point. It's a document before the government for
2 consideration, so --

3 **MR. GRIFFON:** And SCA can't be in the closed session. Is
4 that correct?

5 **MS. DIMUZIO:** That's correct.

6 **MR. GRIFFON:** So we -- I mean I'm not sure how we'd
7 negotiate or discuss technical scope with the
8 contractor if --

9 **MS. DIMUZIO:** Basically what we would be developing is we
10 would be developing questions that would be referred to
11 SC&A for them to respond to. I mean that's how it
12 would work.

13 **DR. ZIEMER:** And understand that this has a practical effect
14 of perhaps stretching things out a little bit because -
15 - but SCA then has a right, as I understand it, to have
16 a certain amount of time to respond to questions that
17 are raised. They are not -- we don't sit there in the
18 room and ask them to respond right at that moment. We
19 have to develop --

20 **MS. DIMUZIO:** Right, within the --

21 **DR. ZIEMER:** -- both the technical and the cost-related
22 questions and then go back to them then, is my

1 understanding.

2 **MS. DIMUZIO:** Right, within the scope of the contract, SC&A
3 has seven days to respond to those questions, so...

4 **MR. ELLIOTT:** It's also a redirection, too. If the Board
5 finds in the technical proposal that the contractor is
6 proposing something beyond or -- or outside of what the
7 scope of the task called for, you can redirect, by
8 comment. And so that -- that, you know, of itself is -
9 - as well as the questions that you formulate, are --
10 are confidential --

11 **MS. DIMUZIO:** Right.

12 **MR. ELLIOTT:** -- in nature.

13 **MS. DIMUZIO:** We can't appear to be leading -- we cannot
14 appear to be leading the contractor to arrive at a
15 certain point. It's more of a direct -- you know, we
16 have these questions and it's -- you know, it is
17 basically that negotiation back and forth, so that's
18 done in closed session.

19 **DR. ZIEMER:** So those are kind of the ground rules on which
20 we need to operate this morning. Let me ask, any --
21 everybody on the Board understand that?

22 **MR. MILLER:** Excuse me, Dr. Ziemer.

1 **DR. ZIEMER:** Yes, sir?

2 **MR. MILLER:** Could I just raise a question on this? Is
3 there a practical way to solve this? Because the
4 technical scope of what the audit is going to be is of
5 significant public interest. We're not interested in
6 the money side, you know, the independent government
7 cost estimate part. But it seems to me if there's a
8 practical way to solve this would be if the -- if NIOSH
9 would make available the accepted bid proposal that was
10 submitted with Sanford Cohen & Associates' original bid
11 that was made to the government that was accepted, I
12 presume, by the -- whatever source evaluation board you
13 had, so that there's some sense about what the
14 structure, the organization, the methods that are going
15 to be used, the approaches, what the -- what the items
16 are that they're even going to do. I mean to --

17 **DR. ZIEMER:** Well --

18 **MR. MILLER:** -- to -- to go into secret --

19 **DR. ZIEMER:** Let me --

20 **MR. MILLER:** -- and to have discussion about what those
21 items are --

22 **DR. ZIEMER:** I understand your point, Richard --

1 **MR. MILLER:** -- without any public --

2 **DR. ZIEMER:** -- but let me -- let me point out to you that
3 the scope of the work has been defined by the Board.
4 That is a public document. Our determination is
5 whether or not this company is responsive to our scope
6 and what the costs will be to carry that work out. So
7 the scope is public. We have several tasks. They have
8 been defined. We have to determine whether or not this
9 company is in fact capable of responding to those
10 tasks. You will hear about the organization of the
11 company and their personnel.

12 The question on the original proposal, I don't know the
13 legal answer to that. I -- it's a procurement issue.
14 Perhaps Martha can speak to that.

15 **MS. DIMUZIO:** We did pose this specific question to our
16 procurement office about is there any way that the
17 proposal as it's been submitted can be supplied to the
18 public, and basically at this point it's through a
19 Freedom of Information request that would be considered
20 by the procurement office as to whether or not the
21 document is releasable, working with Sanford Cohen to
22 make that determination whether or not anything within

1 that proposal was proprietary or so forth.
2 But I think it's important to point out that while SC&A may
3 have developed an approach and everything, not that
4 there's anything wrong with that approach, but it may
5 not be the approach that the Board wants. And so I
6 think we need to, you know, have that discussion --
7 that's a discussion that needs to be held in private,
8 whether or not the way Sanford Cohen has determined to
9 approach the work that needs to be done is the way that
10 the Board intended it to be. I mean that's one of the
11 issues for the session, the closed session, is to
12 evaluate how their approach has --

13 **DR. ZIEMER:** Is the issue of the original document, is that
14 being pursued or does that require a specific FOIA
15 request?

16 **MS. DIMUZIO:** That would require a specific FOIA request for
17 the original document, as it stands now.

18 **DR. ZIEMER:** I think we were referring to the proposal that
19 --

20 **MS. DIMUZIO:** Oh --

21 **DR. ZIEMER:** -- Cohen originally submitted, which I believe
22 does contain some proprietary information.

1 **MS. DIMUZIO:** As a part of the contract submittal?

2 **MR. ELLIOTT:** Yes.

3 **DR. ZIEMER:** Originally.

4 **MR. ELLIOTT:** I think that's what we're -- they're referring
5 to.

6 **MS. DIMUZIO:** That would be -- yeah -- I need to go back and
7 -- and speak with the procurement office, but I believe
8 if Sanford Cohen is willing to release that
9 information, that that information could be released,
10 yes.

11 **DR. ZIEMER:** We will follow-up on that. You know, I don't
12 want to get into that debate right now, but we -- note
13 is taken of that, Richard. We'll see if it can be
14 released --

15 **MR. MILLER:** Just to be --

16 **DR. ZIEMER:** -- at some point.

17 **MR. MILLER:** -- clear, though, that proposal that Martha was
18 referring to, the original proposal, was incorporated
19 by reference, I believe, in the final contract award
20 that NIOSH posted.

21 **SANFORD COHEN & ASSOCIATES BRIEFING**

22 **DR. ZIEMER:** Thank you. Okay. With that introduction,

1 here's John.

2 **DR. MAURO:** Good morning. I'd like to thank you for
3 inviting me.

4 **DR. ZIEMER:** Wait, John, you need to put it --

5 **DR. MAURO:** A little higher? Okay, is that a little better?
6 Again, thank you for inviting me. I'm glad to be here
7 today. As was mentioned, SC&A was selected -- I guess
8 it was back in October -- to provide technical support
9 to the Advisory Board in fulfilling its mandate under
10 the Act.

11 In November basically we were awarded what's called a task
12 order proposal, which means that from time to time the
13 Board would request SC&A to perform certain tasks. We
14 received our first task order request for proposal in
15 November and we recently -- last week -- submitted our
16 technical proposals to the Board. As they mentioned,
17 they're reviewing that.

18 I'm here today primarily to introduce SC&A, who we are --
19 we're a small company -- and to identi-- let you know
20 our scope of work, what we've been asked to -- to do.
21 And also give you the brief overview of some of the
22 people that are on our team and their backgrounds.

1 Okay, SC&A. We're a small company, do about \$5 million a
2 year in work, and we primarily -- we were incorporated
3 in 1982. Sandy Cohen is a personal friend of mine.
4 I've been working with him now for -- since 1986, and
5 we specialize in doing dose calculations. We're
6 nuclear engineers and health physicists, primarily.
7 We have currently 30 employees and we have 50 associates.
8 We have a way of doing business whereby we have a core
9 group of people that are more senior, like myself, and
10 then we have associates that work with us who are
11 specialists in a wide variety of areas that we bring in
12 to work on particular problems as they arise. So in
13 effect, we -- and this is a -- this is a very effective
14 approach in providing technical consultant services in
15 that we can bring the best people in the world to -- to
16 the table to -- to answer very specific questions. And
17 also it allows us not to carry a large overhead, so we
18 -- what this -- it puts us in the position that we can
19 bring the best people at the lowest price.
20 And we work -- we have our headquarters office in McLean,
21 Virginia, but our -- a lot of our people work out of a
22 virtual office. For example, I work out of my home in

1 Red Bank, New Jersey.

2 Our clients currently are government clients, primarily. We
3 do a lot of work for the Nuclear Regulatory Commission,
4 the Environmental Protection Agency, Centers for
5 Disease Control, FEMA and DARPA. We -- we write
6 reports. We write new reg documents. We write -- for
7 EPA we write baseline risk assessments, technical
8 support documents. Dose reconstructions, we've done a
9 lot of work for CDC for off-site dose reconstruction.
10 We've done -- so we do dose assessment, risk --
11 radiological risk assessment primarily for the
12 government and primarily for agencies that regulate DOE
13 -- so it's, you know -- so we -- I guess one of the
14 reasons for our selection is that as a corporation we
15 really are not tied very closely at all to DOE. We're
16 more closely tied to EPA, NRC, Defense Nuclear
17 Facilities Safety Board, folks that regulate Department
18 of Energy.

19 However, we do have a -- we have a laboratory, and our
20 laboratory does radiological analysis of samples from
21 anyone that sends us -- that wants us to do, and we are
22 doing some work from samples that come from the State

1 of New Jersey, but also from Savannah River, from -- I
2 guess it's CH (Inaudible) out at Rocky Flats, so that -
3 - that really is the place where we're -- we're doing
4 some work for DOE through our laboratory analysis.
5 By and large, we're a consulting company to government
6 agencies, and I'm proud to say now we are working for
7 NIOSH, also.
8 Our organization -- we have a simple organization. The
9 president and owner of the company is Dr. Sanford
10 Cohen. He's a Ph.D. nuclear engineer. He started the
11 company in 1982, and he is a personal friend of mine.
12 And he in fact will be the back-up. If for any reason
13 -- I got eaten by an alligator or whatever -- Sandy is
14 my back-up on this project. I'm the project manager.
15 The person -- our chief operating officer, Greg Beronja,
16 he's there to make sure we make money. He -- he runs
17 the operations. He has a -- he's a chemical engineer
18 with an MBA.
19 But then the -- really the heart, the operation where -- the
20 people in the trenches are these four boxes. We have
21 four divisions in the company. The original company
22 that was doing lots of work for NRC and EPA is now

1 called the consulting division. I head the consulting
2 division. That division, as I said earlier, consists
3 of anywhere -- at any point in time, between 10 to 20
4 people doing -- writing new reg documents and other
5 types of paper (Inaudible) newspaper.

6 We have -- the other division is the laboratory, and they do
7 radiological analysis. Their specialty is
8 transuranics.

9 We have a field division, folks that go out -- and this is a
10 relatively new division. They go out and perform
11 measurements. If you folks are familiar with
12 characterization and close-out surveys, Bill Ulicny is
13 -- leads up that division and it's a -- it's just a
14 start-up operation. We have a few -- a few private
15 clients.

16 And finally we have what's called the quality assurance
17 division, another smaller division within the company,
18 and Patrick Kelly heads that up and he does audits.
19 Right now he's doing some audits related to I guess
20 (inaudible) whereby these waste packages are being
21 produced and -- for -- for disposal and there's very
22 formal auditing process to make sure those packages

1 meet certain criteria. We drafted Patrick to help out
2 a bit 'cause that's what he does, audits, and -- but --
3 but all of the work that will be done in this project
4 is going to be done out of my division, consulting
5 division.

6 I put up the organization chart -- we'll talk about the
7 individuals, and it's probably hard for you to read
8 anyway. I should have made it a little larger. But
9 the concept of operations, the way we organize
10 ourselves, is that I -- I'm the project manager and I
11 will be available to this project full time, if
12 necessary. I'm here at -- to serve the -- the Board.
13 I have been -- I'm a key individual on the project. I
14 cannot be replaced unless written authorized approval
15 by the Board. I re-- and I report to the Board.
16 Probably there's also an administrative relationship
17 between the Board and NIOSH, but my understanding is
18 that I will be reporting to you folks and to get all my
19 direction from you folks.

20 I have a deputy project manager, Joe Fitzgerald. Some of
21 you folks may know him. He has a lot of background at
22 the Department of Energy. He has an indep-- he has his

1 own company. We brought Joe's company, Salient, in as
2 a subcontractor to SC&A.

3 You'll see, as we go over the backgrounds of these folks
4 here, we -- we have -- we've done a lot of off-site
5 dose reconstruction for CDC. We've done a lot of risk
6 assessment and dose assessment for EPA and the NRC, but
7 we don't know, as a company, the DOE complex and the
8 issues that you folks are dealing with. Joe brings to
9 the table this know-how, which we consider to be very
10 important.

11 We've broken up -- what I have -- the way I've arranged the
12 organization is a staff that crosses -- that will be
13 supporting me. One I call quality assurance. A lot of
14 folks are not familiar with the concept of quality
15 assurance versus quality control. We all come out of
16 the nuclear industry where that's our life's blood. If
17 it is -- we have to follow very rigorous protocols to
18 ensure quality. We have Dr. Steven* Ostrow, who is
19 going to basically provide audits of our work to make
20 sure that we do everything in accordance with the
21 procedures that we have written up in our plan to you
22 folks, and he will be auditing that to make sure we do

1 that.

2 And to the right of me on this org. chart is our records
3 management specialist. We'll be tal-- I'll be talking
4 about these people a little bit more when we get into
5 each individual, but we -- our vision of the project is
6 that it's going to be ve-- it's critical that we
7 maintain a complete record that will be accessible to
8 the Board. All of the information we use should be
9 completely transparent. And I realize there's going to
10 be a lot of hard copy and electronic versions. Some
11 documents might need to be controlled, so we have a
12 records management specialist. I'll tell you a little
13 bit more about Kathy Behling when we get into the
14 individuals.

15 Then we've broken up the project functionally according to
16 the scope of work that we would be covering. We have a
17 -- our -- a large staff to do the reviews of the
18 individual dose reconstructions. We have a -- the
19 center box there is to do worker and site profile
20 reviews. And then we have a third box which is SEC
21 petition reviews and supporting that aspect. So we've
22 broken up ourselves functionally into those areas.

1 Reality is, on projects like this, it has to have a certain
2 fluidity to it. All of the people that we were talking
3 about are -- are available to work basically on
4 whatever is needed.

5 The bottom half -- bottom half box, what we did is we went
6 out and tried to find the best people we could -- this
7 is where this associate relationship becomes very
8 valuable -- in all of the areas that we felt were
9 important to have access, ready access to powerful
10 expertise to be brought in as needed to -- to get the
11 job done. So we have a total of about 31 people that's
12 available to the project.

13 And we -- one more point that I'd like to make is we also
14 put in place a very powerful conflict of interest
15 control process. We understand the importance of
16 conflict of interest. And everyone that comes aboard
17 and is part of our team has to go through a vetting
18 process before they can be part of the team to make
19 sure that we meet all conflict of interest issues. So
20 no one comes aboard unless you say it's okay, and we
21 have a process to do that.

22 Let me just introduce -- what I've done in the org. chart is

1 I've identified what I call lead individuals. These
2 are -- this is the heart of the operation. I'm going
3 to just give you a brief biosketch on each person so
4 you get to know who we are.

5 I'm the project manager. I have a Ph.D. in health physics
6 from New York University Medical Center. I studied
7 under Dr. Merrill Eisenbud, and many of you folks may
8 remember Merrill. I have also been certified as a
9 health physicist since -- continually since 1976, and
10 my whole life has been doing dose calculations.

11 Kathleen Behling, she is our records management specialist.

12 She has an associate's degree and 30 years experience
13 in records management. She spent a large part of her
14 career responsible for records management at GP Nuclear
15 and maintaining all the occupational exposure records
16 electronically and at -- in our -- at our company, and
17 she's been with us now for about ten years, maybe
18 longer. She does all our records management work
19 related to our dose reconstruction work for CDC.

20 As you can imagine, when you do an off-site dose
21 reconstruction -- in fact I -- work we did a while back
22 for CDC involved 65,000 boxes that we had to go through

1 and -- and create electronic files, vet them out and
2 collect electronic files, and she was responsible --
3 together with our database management people -- to
4 create this bibliographic database, so she's -- she's
5 the records management specialist.

6 Hans Behling. Hans Behling has a Ph.D. in health physics
7 and a master's in public health, 35 years experience.
8 He spent many years at the (inaudible) after TMI to get
9 -- straighten out the situation. He is -- as far as
10 I'm concerned, I've been working with him now for ten
11 years -- one of the best health physicists I've ever
12 met, and he's a pit bull. He will dig and he will dig,
13 and he has a great deal of experience in dose
14 reconstruction.

15 Our company was hired by the Republic of the Marshall
16 Islands on behalf of the claimants who were concerned
17 that they were not getting treated right in their
18 compensation for their claims, and we were asked to
19 reconstruct the doses to the people of Marshall Islands
20 from the Bravo test. The Bravo test is an infamous
21 test that resulted in very large exposures to a large
22 number of Marshall Islanders and we were asked to come

1 in an independently dig through ancient records to
2 reconstruct the doses that were experienced by the
3 people of Marshall Islands. We came and -- our
4 findings were very interesting. We believe the
5 government underestimated the thyroid doses by about a
6 factor of ten, and the whole body doses by about a
7 factor of two, and that's very controversial -- getting
8 a lot of heat on that, but we've got the evidence.

9 Victor Evdokimoff, Victor is a certified health physicist.

10 His entire career was dedicated to hospital health
11 physics. He was the -- he is recently retired as the
12 RSO for Boston University Medical Center. And Victor
13 is recently retired from that position and he's with
14 SC&A now.

15 Joyce Lipsztein, Joyce is a -- has a Ph.D. in health
16 physics. She also went through the same program that I
17 went through at New York University Medical Center
18 under Dr. Eisenbud, and she's I guess perhaps one of
19 the lead-- world's leading experts on internal
20 dosimetry. She knows IMBA like her own name. She
21 could -- she could talk the talk, so we are so pleased
22 because she also recently retired as a professor and

1 has joined SC&A and she's available to us full time, so
2 we have access to what I consider to be one of the
3 world's experts on internal dosimetry and all of the
4 software, including IMBA, that's used to reconstruct
5 doses.

6 Arjun Makhijani, you folks know Arjun. Arjun is an advocate
7 for worker rights and we feel that -- and -- but also
8 he is a superb scientist. And so he brings to the
9 table what I believe is -- how do I best say this?
10 When you're in -- when you work in the nuclear
11 industry, you know, sometimes your bills are being paid
12 by the Nuclear Regulatory Commission or the Department
13 of Energy, and what we have here is a mix of people
14 that come from many diverse backgrounds. Arjun is a
15 strong advocate for -- for worker rights. He will --
16 he will lead up the SEC petition reviews, and -- and
17 he's available to us -- he's one of the individuals
18 that's only available to us about half-time. Everyone
19 else here is available to us just about full time.

20 Steve Ostrow I mentioned earlier. He's in charge of quality
21 assurance. He's going to be the watchdog to make sure
22 we're following our procedures and fulfilling our

1 obligations under our standard operating procedures.
2 Bill Ulicny, we drafted him from our field program. He's a
3 great health physicist. He's one of the younger
4 members of the team and he will be a case manager.
5 Oh, one of the points I'd like to make regarding the way we
6 think about this project is we are -- we believe in the
7 concept of a case manager. That is, every case that we
8 review, there will be a person who we -- who will be
9 held accountable for making sure that case is processed
10 properly. And so we have identified a number of people
11 who will serve as case managers, and they have the
12 freedom to draw upon all the resources of the -- of our
13 project team and more, if necessary. We'll go outside
14 and get whatever is necessary. So Bill will be one of
15 our case managers.
16 And finally is Joe Fitzgerald. He's the president of
17 Salient, a recently-formed corporation. They're a
18 subcontract to us, and as you know, Joe is a -- very
19 knowledgeable on the DOE complex.
20 Okay. With that, you have a pretty good idea of who SC&A is
21 and the people that will be working on this project. I
22 now will just briefly go over the scope of work that we

1 were asked to -- to write a proposal for. This came in
2 back in November, and as I mentioned, on December 2nd
3 we filed our proposal.

4 Task one is -- is the big task. It involves us doing
5 reviews of 70 basic dose reconstructions, 70 advanced
6 dose reconstructions and ten blind dose
7 reconstructions. And we haven't yet received any of
8 the -- I guess you would call it the administrative
9 records, so how we're actually going to staff to get
10 that work done will depend very much on what -- what
11 the issues are and we'll staff it accordingly. And we
12 will certainly keep you apprised of how we're doing
13 that once -- once we get the ball rolling.

14 We've also been asked to support each of the Advisory Board
15 meetings, so every one of these meetings, we'll --
16 we'll be here and we will be giving briefings on what
17 we found out so far.

18 We've also been asked to take a look at -- apparently there
19 are procedures that have been prepared by -- by NIOSH
20 to review the SEC petitions, and we've been asked to do
21 a critical review of that.

22 And then of course in number six there, these are -- there's

1 a lot of deliverables, there are lots of reports that
2 we will be delivering. And all of this work -- this
3 will be performed over a one-year period, once we get
4 the green light to proceed.

5 Task two focuses in on site profiles. Basically -- and this
6 would be -- the site profile work on this project, as I
7 mentioned, is -- is -- would be headed up by Joe
8 Fitzgerald, and he will be drawing upon all the
9 resources of -- of our organization. Not only the
10 organization chart we showed here, but whatever it
11 takes to get the job done.

12 Basically the TORP, the task order request for proposal that
13 we received from the Board and from NIOSH, identified a
14 possibility that this coming year we may be asked to do
15 a critical review of -- of 16, up to 16 site -- site
16 profiles, and part of that work will include not only
17 reviewing it for completeness, but also performing what
18 we call worst-case analysis. That is, given the data,
19 use that data to evaluate what we think the upper bound
20 doses might have been associate with particular
21 operations for each one of these. And that's where we
22 bring in again our team of health physicists. So you

1 always think about you have the -- the radiological
2 engineers and the health physicists looking at the site
3 profiles, and then we have a team of specialists like
4 Joyce who will help in evaluating what they call worst-
5 case scenarios. A part of that work will include
6 making visits to the sites and -- and digging and
7 digging and digging to make sure that we turned over
8 every stone to make sure the site profiles are as
9 complete, that -- that -- as they can be.

10 Task three, you're probably familiar with the OCAS -- I
11 guess it's IG-1 and IG-2. These are the procedures
12 that are currently being used by NIOSH and their
13 contractor to perform external dose reconstruction and
14 internal dose reconstruction. But in addition to that,
15 there are also -- we became aware of a large number of
16 additional procedures that have been prepared by NIOSH
17 contractors, and these basically are the procedures
18 that they're following -- they're technical procedures.

19 So this task basically involves us performing a
20 independent technical review of those procedures.

21 We believe that the same people that are reviewing the dose
22 reconstructions should also be the people reviewing the

1 procedures, so they will be responsible for doing --
2 the same people will be working on task three as are
3 working on task one.

4 Finally our fourth and last task is called the dose
5 reconstruction review tracking. What -- what this is
6 is that we're -- we're going to generate a great deal
7 of information. I mean beside the records, electronic
8 or hard copy, we receive regarding the cases or
9 regarding the site profiles, we will be receiving -- we
10 will be filling out -- the way we are approaching the
11 project is a very, very formal documentation process of
12 audits where each review follows an audit procedure,
13 check list, sign-offs, and so we're going to be
14 generating a lot of data and information. Our plan is
15 to build a database management system that is
16 compatible or integrated with your Sequel* 2000 that
17 will allow the Board to -- to basically do sorts on --
18 on the records, that data that's in there, that will
19 help serve your purposes in tracking performance, doing
20 statistical workups of the data. So -- and so -- we
21 have Don Loomis who specializes in database management
22 system. I know -- Sequel is his -- he knows Sequel the

1 way Joyce knows IMBA, so we -- we feel very comfortable
2 that we can design and build for you whatever you need.

3 And it's easy to do. He says don't worry about this
4 one. The others are going to be some tough ones.

5 Don't worry about this. We'll -- we'll build whatever
6 you want.

7 And that -- that really concludes my overview. I'd like to
8 just make one statement. I've been in -- I've been
9 doing dose calculations for 30 years. This is the most
10 important project I've ever been on and I'm very, very
11 pleased that you selected us. Thank you. Any
12 questions?

13 **DR. ZIEMER:** Thank you very much, John, for that overview of
14 your company and capabilities. We'll now open the
15 floor for questions from the Board. Again, I'll remind
16 the Board members that you pretty much need to confine
17 your questions to the material that John has presented
18 here. That restricts your questioning right away,
19 doesn't it?

20 John, you indicated that in addition to the roughly 30
21 folks, you have the capability of bringing others in on
22 rather short notice. Is that correct?

1 **DR. MAURO:** Yeah, we've -- we've built up -- right now we
2 have 50 active associates. We have 30 full-time
3 employees and 50 active associates. However, we've --
4 we develop associate -- we actually at one time had
5 perhaps 200 associates, so we have a relationship with
6 a -- a network that -- that -- throughout the United
7 States of -- for example, you'll notice Art Upton is on
8 our org. chart.

9 **DR. ZIEMER:** Uh-huh.

10 **DR. MAURO:** Well -- or Doug Boreham -- I don't know if you
11 know Doug, he was up at (inaudible) University. He
12 specializes in biomarkers. These -- these are folks
13 that are -- that I consider to be the best people there
14 are out there to address particular questions. We have
15 a list right now of hundreds of specialists in all the
16 radiological sciences and the nuclear sciences that --
17 that we have an ongoing relationship with. I mean all
18 of the -- the key people -- you'll notice by the list
19 of names here, we -- we all have 30 years experience
20 under our belt. Collectively we have a network of
21 relationships, of people that we can draw upon. So
22 when special problems arise -- in fact, for example,

1 before the Board -- I don't know this individual, but
2 is a Dr. Hunt who's -- I believe Great Britain, that
3 Joyce said listen, you -- we've got to get Dr. Hunt
4 abo-- available because there's no one who understands
5 film badge dosimetry and converting film badge readings
6 to organ doses better than he does, so we brought him
7 aboard. We envision that there are going to be
8 problems that are going to come up that are going to be
9 very specialized. And so what I'm saying is that what
10 we're in a position to do is very quickly bring aboard
11 associates within a day -- for some reason, if we have
12 a need -- so we -- there's no boundaries. We can
13 either do that, or we can bring aboard a subcontractor.
14 That's more of a difficult thing to do. There are
15 companies that have certain specialty expertise that
16 you may want to bring in. We're very much open to
17 doing that. But usually that takes a little longer
18 because we have to put the contract in place, and the
19 vetting process regarding conflict of interest becomes
20 a little more burdensome. But -- but yes...

21 **DR. ZIEMER:** Okay, thank you very -- oh, here's a question.

22 Roy DeHart.

1 **DR. DEHART:** I actually was going to ask the question, but
2 you answered it as you were talking through, and that
3 is most of our -- essentially all of our cases that
4 we're going to be reviewing have medical problems.
5 They have cancer. And I noticed that there was the
6 absence of any physician being listed, but when you
7 mentioned Art -- you took care of that issue.

8 **DR. MAURO:** Okay, right. Yeah, Art and I are -- are
9 friends. He -- he was part of the NYU -- New York
10 University Medical Center program and over the years I
11 -- we've been working with him. He's been an SC&A
12 associate for many years.

13 **DR. ZIEMER:** Okay, thank you very much. We appreciate your
14 being here today.

15 **REVIEW AND APPROVAL OF DRAFT MINUTES, MEETING 18**

16 We now have opportunity for a working session. We have
17 several items that we need to address. First of all,
18 beginning with the minutes to the 18th meeting -- let
19 me get my copy back from Ray here. I'd like to ask
20 Board members for any additions or corrections to the
21 minutes.

22 Let me begin by indicating that in the executive summary I

1 have asked Ray to insert on -- looking for a page
2 number here. It's the first page of the executive
3 summary. It would be the third section under OCAS
4 Program Status Report, David Sundin's report where he
5 announces the number of claims to date. I asked Ray to
6 insert the number of claims in the summary here so that
7 it is more specific in the executive summary.

8 Likewise at the top of the next page where it indicates four
9 completed site profiles, to identify those four sites
10 in the executive summary.

11 Now other -- other comments? And again we're asking for
12 substantive ones as opposed to simply grammatical. Did
13 you all check those items that are attributed to you to
14 make sure -- Wanda, you have one that you wanted to
15 raise, I believe.

16 **MS. MUNN:** I have two. On page 20 where Ms. Munn begins
17 talking. We've just finished talking about the
18 procedure for individual dose reconstruction, and it's
19 not clear to me in that sentence exactly what I was
20 talking about.

21 **DR. ZIEMER:** Let's make sure at page 20 -- page 20, I'm
22 looking to make sure because I have a downloaded

1 version which seems to have ended up with different
2 page numbers and so on, but --

3 **MS. MUNN:** All right, the --

4 **DR. ZIEMER:** -- this is the copy that was in our packet, I
5 guess.

6 **MS. MUNN:** Yes, in the center of the page, the motion to
7 approve the procedure for processing passed
8 unanimously.

9 **DR. ZIEMER:** Okay.

10 **MS. MUNN:** And then the next sentence, Ms. Munn indicated
11 she was still concerned about the large number of site
12 profiles being required.

13 **DR. ZIEMER:** Okay, so to -- for clarity, to add the words
14 "of site profiles" --

15 **MS. MUNN:** "Of site profiles being required." Because our
16 discussion was about how quickly these were going to be
17 done.

18 **DR. ZIEMER:** Right. And so without objection, we'll add
19 that.

20 **MS. MUNN:** And the other concern, page 32, second paragraph.
21 Jim Neton was talking here and the first sentence of
22 the second paragraph says "Determination of external

1 doses was covered by general considerations,
2 unmonitored workers." I'm not certain exactly what
3 that means. I think I'd have to go back to the
4 transcript to get the full sense of that, but that
5 sentence appears to need some grammatical correction of
6 some sort. I'm not sure exactly what.

7 **DR. ZIEMER:** Yes, it's -- does not appear to be clear to --
8 does anyone know what -- Jim, she's attributing this to
9 you.

10 **DR. MELIUS:** No, Jim Neton.

11 **DR. ZIEMER:** Oh, to Jim Neton. Oh, oh, the other Jim.

12 Okay. Okay, so we will ask for that sentence to be
13 clarified.

14 Does that cover the ones -- okay. So we don't know how that
15 will be fixed right now, but we will fix it.

16 **DR. MELIUS:** Just put a mumble in there. Dr. Melius
17 mumbled; couldn't understand a word he was saying.

18 **DR. ZIEMER:** I found the Gen Roessler statement that I was
19 trying to understand.

20 **DR. ROESSLER:** Okay.

21 **DR. ZIEMER:** It's on page 32. It's bullet five. Dr.
22 Roessler asked what part of the total was assumed for

1 the chest X-ray. What part of the total.

2 **DR. ROESSLER:** I think on that Jim was talking about typical
3 doses to workers, and he had a chart up and he showed
4 chest X-ray and I -- I kind of thought that was a maybe
5 a major part of the dose and so I asked him
6 specifically what -- what dose was due to the chest X-
7 ray, and he didn't specifically have an answer. He
8 just said it would be typical for whatever was used in
9 medical facilities at the time. Does that help?

10 **DR. ZIEMER:** What part of what total? A typical total
11 worker dose? Is that --

12 **DR. ROESSLER:** I think that's what he was talking about, as
13 best I can remember. We might have to go back to the
14 slides he was using, but I seem to recall he had one
15 slide where he showed a typical dose and he included a
16 chest X-ray.

17 **DR. ZIEMER:** So it would be something like what part of the
18 total in the example? Well, perhaps we can ask that --
19 that that --

20 **DR. ROESSLER:** I think we need to the record.

21 **DR. ZIEMER:** It's not clear to me exactly what they're
22 talking about.

1 Other -- other items that anyone wishes to call attention
2 to? Did you have another one, Wanda, or is --

3 **MS. MUNN:** No.

4 **DR. ZIEMER:** Okay. No others? Let me ask for -- if the
5 group is willing for us to make appropriate fixes to
6 those two spots, if you then are willing to approve the
7 minutes, including the executive summary, as slightly
8 modified. Is there a motion to that effect?

9 **MS. MUNN:** So moved.

10 **MR. PRESLEY:** Second.

11 **DR. ZIEMER:** It's been moved and seconded. All in favor of
12 approving the minutes, subject to relatively minor
13 fixes, please say aye.

14 (Affirmative responses)

15 **DR. ZIEMER:** Any opposed?

16 (No responses)

17 **DR. ZIEMER:** Motion carries.

18 (Pause)

19 **DR. ZIEMER:** Larry wants to ask a question relative to
20 minutes.

21 **MR. ELLIOTT:** These minutes are very detailed in their
22 content, and I would just ask for the Board's sense on

1 what you would be happy with. Is this what you're
2 happy with as far as your minutes, or would you --

3 **DR. ZIEMER:** As far as level of detail, I think you're
4 asking.

5 **MR. ELLIOTT:** Right. Or would you prefer perhaps to see
6 something like the executive summary, six pages or
7 less, and then use the transcript to rely on that, on
8 what the verbatim is to what was actually discussed and
9 held. How would you --

10 **DR. ZIEMER:** Yeah, just give us some feedback on this.
11 We've been trying to condense them and they're --

12 **MR. ELLIOTT:** Cori, am I correct that -- that this executive
13 summary and then the full text of minutes that we are
14 using is not -- it's something we can change. We can --
15 the Board wants to have just an executive summary
16 style set of minutes, they can do that.

17 **MS. HOMER:** (Off microphone) We have some (Inaudible) can be
18 met in a much shorter version.

19 **MR. ELLIOTT:** Yes.

20 **DR. ZIEMER:** Jim.

21 **DR. MELIUS:** Yeah, I actually like this particular style, so
22 I speak in favor of keeping it. I think --

1 **DR. ZIEMER:** About this level of detail?

2 **DR. MELIUS:** About this level of detail, 'cause I think it
3 is helpful to be able to not have to refer back to the
4 transcripts to find what someone said at this point in
5 time.

6 **DR. ZIEMER:** Gen Roessler?

7 **DR. ROESSLER:** I think we owe this amount of detail to the
8 people who are looking at our minutes, and I know there
9 are people -- particularly in health physics -- who are
10 reviewing what we're doing, and I think we need at
11 least this much detail.

12 **DR. ZIEMER:** Okay. Mark, did you also have a comment?

13 **MR. GRIFFON:** Just the -- the same comment as Jim, that not
14 -- not too many people are going to turn to the
15 transcripts, so I think this level of detail is good.

16 **DR. ZIEMER:** Okay. Other -- any others want to weigh in one
17 way or the other? Do you want them shorter, longer,
18 this feel --

19 **MR. PRESLEY:** I agree.

20 **DR. ZIEMER:** Seems to be a sort of a general consensus that
21 maybe we're at about the right level. Okay. Thank
22 you, that's very helpful.

1 Okay, Ray, I think --

2 **THE COURT REPORTER:** Who made the second to approve them? I
3 didn't hear --

4 **MS. MUNN:** Presley.

5 **DR. ZIEMER:** I'm sorry?

6 **THE COURT REPORTER:** Who made the second to approve these
7 minutes? I didn't see it.

8 **DR. ZIEMER:** Who made the second to approve the minutes?
9 Okay. Robert, thank you.

10 (Pause)

11 **BOARD DISCUSSION/WORKING SESSION**

12 **DR. ZIEMER:** One of the issues that arose at our last
13 meeting -- and I'll simply remind the Board of it and
14 then we can handle it as you see fit -- was whether or
15 not we should have a -- a subcom-- put in place a
16 subcommittee, as opposed to a working group, a
17 chartered subcommittee to handle the ongoing issues
18 relating to dose reconstruction and our interactions
19 with the contractor. It may be that the Board will
20 wish to delay that decision on establishing a working -
21 - or a subcommittee until after we have a chance to
22 review the contractor's proposal later today. But

1 nonetheless, let me ask if the Board does at this time
2 wish to move forward on that issue or -- in the absence
3 of that, we remain operating as a committee of the
4 whole on the issue of how we direct and work with our
5 contractor. I'll open that for any comments or
6 specific recommendations. Begin with Dr. Melius.

7 **DR. MELIUS:** I agree, it's difficult to talk about this with
8 specificity now until we've gone into closed session.
9 However, I think -- I am a little uncomfortable about
10 us making major changes in Board procedure or sort of
11 the issue of the public's access to what we're -- to
12 our activities and so forth -- to do that in closed
13 session. So I think it would be worthwhile having some
14 discussion of the concept and -- of subcommittee and at
15 least some sense of where we --

16 **DR. ZIEMER:** Yeah.

17 **DR. MELIUS:** -- where we should go with it and what the sub-
18 - a subcommittee or working group might -- might do or
19 not, but recognizing that we may have to sort of
20 develop the specific charge for the subcommittee in
21 closed session, given the situation, that all we can do
22 right now is --

1 **DR. ZIEMER:** No, actually this could not be part of our
2 closed session today.

3 **DR. MELIUS:** Okay, that was actually --

4 **DR. ZIEMER:** I'm sorry if I suggested that. I suggested
5 that the decision on doing that may need to wait till
6 the results of the closed session are known to us. But
7 we -- we would not -- we cannot carry out other
8 business in the closed session other than reviewing and
9 addressing the cost proposal that is before us. This,
10 of necessity, must be an open session item. So -- and
11 all I'm saying is that unless we choose to do something
12 this morning on that, we would defer and would continue
13 to act as a committee of the whole until our next
14 meeting, at which point we could decide to establish a
15 subcommittee on an ongoing basis. There's not a
16 necessity that we have a subcommittee at the moment.

17 **DR. MELIUS:** Yeah, can I just say two things to address
18 that? And some of this is going to be a question for
19 Larry. One is that I think first of all we ought to
20 look and -- and see what -- what we might lose or gain,
21 depending on what happens this afternoon, in terms of
22 timing of task orders and so forth if we -- I think our

1 next meeting's what, about two months away -- until
2 then 'cause -- I mean I think if -- to the extent we
3 could facilitate this moving forward through a
4 subcommittee, I think it would be -- be good. It may
5 be that we would then -- so that's one question. The
6 second question is I think it would be worthwhile
7 having a larger discussion of what a subcommittee might
8 do on an ongoing basis. We may have to defer the
9 decision on that to the -- to the next meeting. But I
10 wouldn't see -- there certainly might be some value to
11 having a subcommittee that would last until the next
12 meeting and would have a very specific charge to it in
13 terms of what it -- it might do, though I'm not sure
14 what that charge would be until I understand the
15 process, and even then I'm not sure we can do anything
16 in this session on a contingent basis --

17 **DR. ZIEMER:** Yeah, a subcommittee that lasts until our next
18 meeting looks much more like a workgroup as it's ad hoc
19 and very specific. But unless -- right now we would be
20 operating in the absence of having a precise knowledge
21 of what the charge would be to such a workgroup.

22 **DR. MELIUS:** Well, I think we could -- well, I'm not sure

1 'cause I'm not sure what the procedure is. I would
2 think that, though -- that a -- as I understand it, a
3 subcommittee can take actions on behalf of the Board
4 between meetings; a workgroup cannot.

5 **DR. ZIEMER:** If the Board so authorizes.

6 **DR. MELIUS:** Correct. Correct. And so I guess my question
7 is, number one, in the short term -- and this question
8 I think is to Larry -- given the process, given what
9 might occur this afternoon -- you know, what are the --
10 what are the possibilities this afternoon, and then do
11 any of those possibilities...

12 **MR. ELLIOTT:** I think --

13 **DR. MELIUS:** -- would be assisted by having action by the
14 next meeting.

15 **MR. ELLIOTT:** I think it would be beneficial for the Board
16 to hear again the process from -- from this point
17 forward, and that'll give you a better sense of, you
18 know, what kind of a delay might occur and how you
19 might react to -- to that. So I'd ask Martha if she
20 would again cover the ground of how -- how this thing
21 is going to -- going to work.

22 **MS. DIMUZIO:** Well, basically, you know, we'll go into

1 closed session this afternoon to review the proposals
2 and -- and the cost estimates that have been provided
3 by Sanford Cohen. The Board at that point can either
4 determine to accept the proposals as -- as -- as
5 they've been submitted, and then we would move forward
6 with award. If there are questions related to the --
7 the approach or level of effort that may -- the
8 contractor may be proposing and things like that and
9 there are specific questions, we would generate those
10 questions, those questions would be forwarded to our
11 procurement office, who would then provide them to
12 Sanford Cohen for response. At that point Sanford
13 Cohen has seven days to respond to those questions and
14 potentially re-propose against those four tasks, and
15 that point in time we would have those proposals to
16 forward out back to the Board for them to approve.

17 **MR. ELLIOTT:** And you can put forth an extension of time if
18 -- if appropriate and necessary and justified.

19 **MS. DIMUZIO:** Right, yes, if Sanford Cohen needed additional
20 time to prepare their responses or whatever, then yes,
21 I mean we can give them additional time of seven days
22 to respond, yes.

1 **DR. ZIEMER:** Okay, let's go ahead and get some other
2 comments here and then we'll proceed. Let's see, Henry
3 and then Wanda.

4 **DR. ANDERSON:** Yeah, my -- I guess my thoughts are if the
5 intent is to have a subgroup so that we can move
6 expeditiously, I think we could also continue with a --
7 I mean for a subgroup you still have to -- or
8 subcommittee, you still have to post it in the *Federal*
9 *Re--* or you know, you've got to have all the advance
10 notice and all that kind of thing. It would seem to me
11 we could simply do that as a committee of the whole,
12 recognize that the only thing we have to have is a
13 quorum and, you know, if we have to have multiple
14 calls, you know, getting a subcommittee together can
15 probably be more problematic than just getting a quorum
16 from the -- from the Board to address whatever needs to
17 be talked about, but as far as the logistics of doing
18 the announcement, it's not much different, so that
19 might be the way -- and then as activities go, we could
20 see whether there's some more routine activities that a
21 subcommittee would be more advantageous, but I -- I
22 just think we're early on enough that everybody's going

1 to want to see it and probably be involved in the
2 decision process. And we just have to recognize on
3 short notice some people won't make it and we'll just
4 have to be sure that, whatever the call is, we've got
5 the quorum.

6 DR. ZIEMER: Wanda.

7 DR. ANDERSON: You can't do it by --

8 MR. ELLIOTT: By call.

9 DR. ANDERSON: You can't do it by call?

10 MR. ELLIOTT: No. You cannot hold a closed session --

11 DR. ANDERSON: No, no --

12 MR. ELLIOTT: -- by phone call.

13 DR. ANDERSON: Okay, this would have to be a closed session.

14 MR. ELLIOTT: Yes.

15 DR. ANDERSON: Oh, okay, I was thinking --

16 MR. ELLIOTT: This is a negotiation --

17 DR. ANDERSON: -- a subcommittee action would be --

18 MR. ELLIOTT: This is a negotiation between --

19 DR. ANDERSON: Oh, this is for --

20 MR. ELLIOTT: -- you as the government and your contractor.

21 DR. ANDERSON: Yeah, okay, I see. I thought there would be
22 other issues to look at. Sorry, never mind.

1 **MR. ELLIOTT:** Sorry.

2 **DR. ZIEMER:** It would be equivalent to doing what we're
3 doing this afternoon with a -- some sort of perhaps a -
4 - assuming we needed revisions.

5 **DR. ANDERSON:** Yeah.

6 **DR. ZIEMER:** Maybe we don't.

7 **DR. ANDERSON:** Yeah.

8 **DR. ZIEMER:** But if we did... Wanda.

9 **MS. MUNN:** Although it appears cumbersome to act as a
10 committee of the whole, in the absence of a triggering
11 event or substances that would -- circumstances that
12 would clearly require the more concentrated efforts of
13 a subcommittee, I see no reason for us to further
14 discuss establishing one at this time.

15 **DR. ZIEMER:** Jim, did you have an additional comment?

16 **DR. MELIUS:** I have an additional comment. If I followed
17 you, Martha, correctly -- and I'm guessing at times and
18 given holiday seasons, but my sense is that the
19 earliest go back and forth with Sanford Cohen &
20 Associates would -- end with us getting a new proposal
21 around the first of the year.

22 **MS. DIMUZIO:** That's correct.

1 **DR. MELIUS:** Yeah, so it would be about right. Our
2 meeting's the first week in February, so we would be
3 losing a month of work in terms of -- of tasks, should
4 they have to be revised, et cetera.
5 I guess another question is -- and I don't know that the
6 answer is -- can the process go on more than once? Can
7 we end up going back and forth with them...
8 **MS. DIMUZIO:** Yes, technically you could. I mean if -- if
9 level of effort was still not correct, if, you know,
10 they still didn't fully understand the -- you know, how
11 we wanted them to revise if necessary, then yes, you --
12 you could be going back with -- with a follow-up, yes.
13 **MR. ELLIOTT:** Martha, can there be back-and-forth in written
14 form between the contractor and the full Board?
15 **MS. DIMUZIO:** I believe so. I'd want to --
16 **MR. ELLIOTT:** So for example, on a specific --
17 **MS. DIMUZIO:** -- verify that with --
18 **MR. ELLIOTT:** -- task, if -- if there were --
19 **MS. DIMUZIO:** -- Larry, but --
20 **MR. ELLIOTT:** -- limited questions or issues regarding a
21 proposal on a given task, and the Board puts that
22 together and goes back to the contractor and then they

1 get a revised proposal and it looks okay, the Board
2 could take action on that and make an award by letter
3 to procurement.

4 **MS. DIMUZIO:** Yes, you could do that. You would just have
5 to have some mechanism for all of the Board to approve
6 the questions --

7 **MR. ELLIOTT:** Approve and agree.

8 **MS. DIMUZIO:** -- and review the questions and okay the
9 questions in some type of session that would not be
10 open to the public. But yeah, I mean -- and I don't
11 know how you would --

12 **MR. ELLIOTT:** Cori, is there a way to do that by -- by mail?

13 **MS. HOMER:** (Off microphone) I'm sorry, I was -- the music
14 is a little loud back here.

15 **MR. ELLIOTT:** Okay. I'm trying to get at can the Board
16 conduct some of this business of awarding a task
17 without having a face-to-face meeting and going back
18 and forth between them and their contractor by -- by
19 mail, perhaps, and get a sense that -- that the full
20 Board is in agreement, has a -- has a -- no?

21 **MS. HOMER:** I don't believe so. I -- I could check into
22 that, but the -- any action taken by the Board is

1 considered a meeting, period -- has to be announced.
2 If it's closed, it has to be announced as closed and
3 approval has to be gained for that.

4 **DR. ZIEMER:** Yeah. Actually that sounds true. I mean it
5 sounds -- it sounds like if you tried to do things by
6 letter, you're circumventing the intent of the -- the
7 process so that --

8 **MS. HOMER:** (Off microphone) Yeah, the same -- the same
9 (Inaudible) for a subcommittee, as well.

10 **DR. ZIEMER:** I might add -- and let me ask this -- or
11 perhaps make it a comment and ask a question. If --
12 we're presuming that there might be changes, but maybe
13 there won't. But let's assume that out of today's
14 session the Board raises some comments and asks for
15 feedback.

16 **MS. HOMER:** Uh-huh.

17 **DR. ZIEMER:** And the result is some sort of a revised
18 proposal around the first of the year, as was
19 suggested. If at that point the Board felt that there
20 was some urgency in acting on that new proposal, would
21 it not be possible to announce in the *Federal Register*
22 that in two weeks or something we're going to meet --

1 MS. HOMER: Uh-huh.

2 DR. ZIEMER: -- I don't know, Cincinnati or somewhere for
3 the express purpose, in closed session, of making the
4 final -- taking the final action on that?

5 MS. HOMER: That's possible.

6 DR. ZIEMER: I know it's not optimal.

7 MS. HOMER: No, it's not. We have to have seven days.

8 DR. ZIEMER: But if there's some reason to shorten --
9 otherwise we have the month, quote, loss, but if the
10 Board felt that we can't afford to sit here for a month
11 with nothing happening --

12 MS. HOMER: Uh-huh.

13 DR. ZIEMER: -- we need to go forward, we could meet.

14 MS. HOMER: It would be tough.

15 DR. ZIEMER: I mean whether it was the Board or the
16 subcommittee, you have to do the same thing.

17 MS. HOMER: Yeah, I mean --

18 DR. ZIEMER: You have to make the announcement --

19 MS. HOMER: -- given the appropriate resources, we could --
20 we could pull that off. I mean the -- the --

21 DR. ZIEMER: And could we not --

22 MS. HOMER: -- *Federal Register* notice --

1 DR. ZIEMER: -- even reserve some time in advance for that
2 possibility?

3 MS. HOMER: I would suggest we do that, yes.

4 DR. ZIEMER: And then if we didn't need to use -- use the --
5 it could -- is it easier to cancel an --

6 MS. HOMER: It's very difficult to cancel --

7 DR. ZIEMER: -- announced meeting than it is to add one?

8 MS. HOMER: -- hotel arrangements.

9 MR. ELLIOTT: I think --

10 MS. HOMER: If I have a contract with a hotel, it's very
11 difficult to can-- I'm sorry.

12 MR. ELLIOTT: I think for the benefit of this discussion,
13 though, we -- you could have your closed session and --
14 in the offices --

15 MS. HOMER: Yes, we could.

16 MR. ELLIOTT: -- at NIOSH in Cincinnati. And let's be
17 minimal in what the expectations are to set up that
18 meeting.

19 MS. HOMER: Yes.

20 MR. ELLIOTT: That would be a seven-day advance notice for
21 the *Federal Register* that we'd have to put in.

22 MS. HOMER: We have to have seven days to get it published.

1 It can be published on an emergency basis.
2 Determination to close can probably be rushed. As long
3 as we are not dealing with a contract with a hotel, I
4 don't foresee a problem with that. I mean rooms are --
5 I'm sure we can find lodging for you at a hotel which -
6 - which would not --

7 **DR. ZIEMER:** Larry volunteered --

8 **MS. HOMER:** -- mean a contract.

9 **DR. ZIEMER:** -- four bedrooms.

10 **DR. MELIUS:** I can't wait.

11 **DR. ZIEMER:** I don't want to be in --

12 **MR. ELLIOTT:** I have a tent, too.

13 **DR. ZIEMER:** Jim.

14 **DR. MELIUS:** To me, rather than doing something contingent
15 on a full Board, I think let's explore the subcommittee
16 issue. We've got some time this morning and seems to
17 me that if a subcommittee could be charged -- well, I
18 guess this is the question again. Can the subcommittee
19 be charged with, you know, reviewing a response from
20 the contractor should be -- should it be necessary,
21 based on our meeting this afternoon, and then approving
22 it? And -- and the instructions for that approval, the

1 circum-- you know, whatever you want to call --

2 **MR. ELLIOTT:** With the bounds on it.

3 **DR. MELIUS:** -- with the bounds on it could be, to some
4 extent, set this afternoon by -- by what our
5 instructions are back to the -- I mean I think in
6 essence we end up doing that when we -- the questions
7 and -- should we send those back to the contractor. I
8 mean to me it would be a lot more --

9 **DR. ZIEMER:** What you're proposing if you're bounding it,
10 for example, in terms of dollar values, I don't think
11 we can do that in -- at this point.

12 **MR. ELLIOTT:** You couldn't do that in this meeting.

13 **DR. ZIEMER:** In this meeting.

14 **MR. ELLIOTT:** You couldn't do that in this public meeting.
15 You could -- you could do that in -- if you set up a
16 subcommittee or if you set up, as part of your
17 discussion in the closed session this afternoon, what
18 your expectations are and the next meeting is either a
19 subcommittee or a quorum of this body, that's your
20 guidance.

21 **MS. HOMER:** I would like to --

22 **DR. MELIUS:** And that's going to --

1 **MS. HOMER:** I'm sorry, Dr. Melius, but I would like to point
2 out that you can make the decision to establish a
3 subcommittee, but administratively it still has to be
4 established prior to any meeting taking place.

5 Whatever --

6 **DR. ZIEMER:** Has to go through the --

7 **MS. HOMER:** -- decision that you make --

8 **DR. ZIEMER:** -- CDC process.

9 **MS. HOMER:** Correct, uh-huh.

10 **MR. ELLIOTT:** It has to have a charter.

11 **MS. HOMER:** Yes.

12 **MR. ELLIOTT:** The charter has to be signed off on.

13 **MS. HOMER:** Well, it's an establishment memo that will
14 provide membership, it will provide the function, it
15 will provide frequency of meetings --

16 **MR. ELLIOTT:** Delegation of authority from the Board.

17 **MS. HOMER:** Well, and that's something -- yeah, we would
18 probably have to discuss that.

19 **DR. MELIUS:** How long?

20 **MS. HOMER:** I suspect it could take two weeks. With the
21 holidays, maybe a little longer.

22 **DR. MELIUS:** Christmas Eve we'll...

1 **DR. ZIEMER:** Comment over here.

2 **DR. DEHART:** If I understand, we would need only a quorum of
3 this committee, which is 50 percent plus one, and the
4 odds of being able to find that number to attend a
5 meeting is probably greater than having a subcommittee
6 with limited numbers to be able to meet, so I see no
7 advantage at all at this point to try to create and
8 generate a subcommittee and just have the -- just have
9 us as a whole try to address the issue.

10 **DR. ZIEMER:** Okay. Other comments?

11 **DR. MELIUS:** Yeah, I guess I was just thinking the opposite,
12 that -- that we could establish a subcommittee of say
13 four people and those four people could pick a date a
14 lot easier than whatever the quorum is -- what, six or
15 seven -- I don't even remember what a quorum is, seven
16 --

17 **DR. ZIEMER:** One more than half.

18 **DR. MELIUS:** -- seven, so seven -- four people are easier to
19 meet than seven. The question is, can we come -- I
20 think the real question would be more do we want to
21 spend the time and can we come to agreement at this
22 meeting on a subcommittee charter, or is that going to

1 be something that's going to take us more than one
2 meeting to work out.

3 **DR. ZIEMER:** Well, it's not obvious that four is easier than
4 seven because it's a specific four versus any seven out
5 of 12, so I'm not sure -- it's not obvious to me that -
6 - if it's a specific four, it may be actually harder to
7 find a date, but that's what you're suggesting. And
8 who knows, it depends on who the four are and who --
9 what the dates are, so who knows.

10 Other comments? Henry.

11 **DR. ANDERSON:** I guess the other thing to talk about, what
12 would be the activities going forward of such a -- I
13 think it's advantageous to have a relatively small
14 group which would basically act as our project officer
15 for the Board, as a collective group dealing, so kind
16 of moving forward it would seem to me if there were
17 questions that had to be dealt with --

18 **DR. ZIEMER:** Well, the original idea on this was more of a
19 management type --

20 **DR. ANDERSON:** Yeah.

21 **DR. ZIEMER:** -- of group that would --

22 **DR. ANDERSON:** Yeah.

1 DR. ZIEMER: -- work with the contractor closely, help
2 decide who --

3 DR. ANDERSON: Yeah.

4 DR. ZIEMER: -- which of the Board members would participate
5 in different cases --

6 DR. ANDERSON: Yeah.

7 DR. ZIEMER: -- and so on, as opposed to a specific decision
8 such as this one --

9 DR. ANDERSON: Right.

10 DR. ZIEMER: -- which is on the contract itself. Okay.
11 Other -- a comment, Cori?

12 MS. HOMER: Yes, also something to consider would be that
13 even if a subcommittee has been formed and the
14 establishment has taken place, the Board still has to
15 meet to determine what authority they're going to give
16 to the subcommittee. That's still going to take a full
17 meeting of the Board, at least one.

18 DR. MELIUS: Again, just a question. Wouldn't you do that -
19 - couldn't -- if we did that today, doesn't that
20 establish the charter and the -- the --

21 MS. HOMER: It does establish the charter, but it does not
22 establish the authority that the Board is going to give

1 the subcommittee. Because the way that it works,
2 without any authority, the subcommittee cannot take
3 action without approval of the full Board.

4 **DR. MELIUS:** But --

5 **MS. HOMER:** If the Board decides to give the subcommittee
6 authority to act on their behalf, that authority has to
7 be developed and approved before it can -- you know,
8 before the subcommittee can take any action.

9 **DR. ZIEMER:** Can that authority be given prior to the
10 approval of a charter, which is what --

11 **MS. HOMER:** I would suggest not.

12 **DR. ZIEMER:** -- which is the situation that we would have
13 today.

14 **MS. HOMER:** You could develop them at the same time.

15 **DR. ZIEMER:** But until the charter was approved, the
16 authority could not --

17 **MS. HOMER:** The authority has no -- no -- you have no
18 authority.

19 **DR. ZIEMER:** This is a little knotty, but I think in the
20 interest of moving forward -- and we can return to this
21 -- I think I'm simply going to rule that we will
22 continue to operate as a committee of the whole for now

1 and -- particularly on this issue, and if necessary,
2 try to establish some kind of a -- what I might call an
3 emergency meeting of the Board if we need to do
4 something before our next meeting. In the meantime, a
5 -- more details on the charter can be developed. And
6 actually there is some work that's been going on. Mark
7 and I have worked together on some draft things for a
8 possible charter and -- and may be that we'll have a
9 chance to present that a little later even today, Mark,
10 for this subcommittee.

11 We do need to take a break and then return, so let's take a
12 break till 10:15.

13 (Whereupon, a recess was taken.)

14 **ADMINISTRATIVE HOUSEKEEPING AND BOARD WORK SCHEDULE**

15 **DR. ZIEMER:** This is the time on our schedule that we take
16 care of some administrative/housekeeping issues. We'll
17 first turn the mike over to Cori to see if she has any
18 particular items that she needs to bring to us.

19 **MS. HOMER:** (Off microphone) Just a few things. Am I on?
20 Okay. A couple of things just real quickly. Please don't
21 forget to e-mail Larry your work time for the Board,
22 prep time, any working groups that you -- that you were

1 on or worked for, and your Board time separately. Go
2 ahead and send that to Larry as soon as you can, and cc
3 me.

4 I wanted to mention, I have some trouble getting all of the
5 e-mails quickly. That delays payment for everybody, so
6 please respond as quickly as you can with your time to
7 Larry so that I can get you guys paid quickly.

8 The closed session will be held in the Mesquite I Room, just
9 past the front desk, down that long hallway. It's the
10 first room on your left-hand side. It's taking place
11 as scheduled on the agenda.

12 **DR. ZIEMER:** At 2:00 o'clock at Mesquite --

13 **MS. HOMER:** At 2:00 o'clock at Mesquite I. Now for those
14 that are going on the tour, we have a very, very full
15 agenda for that day. Please dress casually. There
16 will be no cameras, phones, blackberries, palm pilots,
17 no forms of communication allowed, period.

18 **MR. PRESLEY:** Picture I.D.

19 **MS. HOMER:** Uh-huh. Bring water, because there will be ice
20 chests, if you'd care to. And we'll be departing
21 around 6:15, 6:30. I have an agenda and I will make
22 you copies, but I haven't had the opportunity to do

1 that just yet.

2 **DR. ZIEMER:** So you want people in the lobby at 6:15. Is
3 that what you're saying or --

4 **MS. HOMER:** Yes. My apologies, but that's the agenda. They
5 arrive at about 6:15 with the bus.

6 **DR. ZIEMER:** Yeah. And it's a drive out to the test site,
7 an hour and a half, roughly.

8 **MS. HOMER:** Well, they're saying about an hour, hour and 15
9 minutes.

10 **DR. ZIEMER:** Okay.

11 **MS. HOMER:** Please be ready to pay --

12 **DR. ZIEMER:** So what -- what's the time to meet in the
13 lobby, very speci--

14 **MS. HOMER:** Around 6:15, 6:30 --

15 **DR. ZIEMER:** Around? Exactly --

16 **MR. ELLIOTT:** Give it --

17 **MS. HOMER:** 6:20.

18 **DR. ZIEMER:** 6:20.

19 **MS. HOMER:** How's that? That'll give the bus five minutes.

20 **MR. ELLIOTT:** How about if you say this. The bus leaves at
21 6:30.

22 **MS. HOMER:** There you go, the bus leaves at 6:30.

1 **MR. ELLIOTT:** Be there or --

2 **MS. HOMER:** Or miss the bus.

3 **MR. ELLIOTT:** -- miss the bus.

4 **MS. HOMER:** Since we've ordered lunches, for those that have
5 ordered lunches, please be prepared to pay -- I believe
6 it's \$6.95 -- to their guide. I'm not going to be
7 collecting any cash, so --

8 **MR. PRESLEY:** And they do take -- that's all they do take is
9 cash.

10 **MS. HOMER:** Is cash, so -- any questions?

11 **DR. ZIEMER:** It can be in quarters, if necessary.

12 **MS. HOMER:** Yeah.

13 **DR. ZIEMER:** Nickels, for the big spenders.

14 **MS. HOMER:** Period, they will confiscate them.

15 **MR. ELLIOTT:** Not on the bus.

16 **DR. ZIEMER:** What --

17 **MS. HOMER:** That tell -- he was -- David was asking if we
18 could even bring anything on the bus, and we cannot.
19 Leave everything in your room.

20 **DR. ZIEMER:** And by everything, you're talking about --

21 **MS. HOMER:** I'm talking about the electronics.

22 **DR. ZIEMER:** -- any cameras, any --

- 1 **MS. HOMER:** Yes.
- 2 **DR. ZIEMER:** -- electronic things.
- 3 **MS. HOMER:** Uh-huh.
- 4 **DR. ZIEMER:** Don't even bring them there.
- 5 **MS. HOMER:** That's right. They'll be confiscated.
- 6 **DR. ZIEMER:** Permanently.
- 7 **MS. HOMER:** No, they'll be given them back at the end of the
8 tour when we arrive back at the hotel. That's --
9 that's what I've been instructed.
- 10 **DR. ZIEMER:** Thank you.
- 11 **MS. HOMER:** Will that be it?
- 12 **DR. ZIEMER:** Any questions for Cori?
- 13 **MR. ELLIOTT:** When you turn your time in to me, keep in mind
14 that the working group on the Board audit or the --
15 Mark Griffon's working group has now completed its
16 charge and as of yesterday I believe the working group
17 on -- Dr. Melius's working group on evaluating the
18 interview process had completed its charge, so working
19 groups have a finite life and they have -- once they
20 meet their charge, then we can't bill time against
21 them.
- 22 **DR. ZIEMER:** But the time that they spent up till now --

1 **MR. ELLIOTT:** Yes, yes.

2 **DR. ZIEMER:** -- but don't come in two months or three months
3 from now --

4 **MR. ELLIOTT:** Well, the point here is the working group on -
5 - Mark Griffon's working group on DR evaluation
6 essentially completed its charge last meeting, so
7 between last meeting and this meeting there shouldn't
8 have been any -- any effort for that.

9 **MS. HOMER:** Okay. Now did you want to discuss dates for a
10 potential --

11 **DR. ZIEMER:** Yes, that's in fact the next item.

12 **MS. HOMER:** Okay.

13 **DR. ZIEMER:** Let me remind you that we have -- we are slated
14 for the 5th and 6th of February, the meeting site being
15 Augusta. And we may want to identify a contingency
16 site in early to mid-January. This is -- we do require
17 I think the presence of the Federal official, so we
18 need as a front end -- I know that Larry's schedule I
19 understand is pretty busy in January and so Larry, are
20 there -- I think we start with you and I guess we also
21 are required to have a Chair.

22 **MR. ELLIOTT:** I think so.

1 **DR. ZIEMER:** But my guess is that your schedule in January
2 is probably tighter than mine. I have decided not to
3 attend the Citrus Bowl game on January 1st where Purdue
4 will play Georgia, and my only conflict right now is
5 the 30th of January, so I'm okay. Where are you,
6 Larry, on --

7 **MR. ELLIOTT:** January 12th, 13th and 14th I plan to be in
8 Richland with the site profile team disseminating that
9 bit of information out there in -- for the Hanford
10 folks, so I'll be on travel then.

11 **DR. ANDERSON:** (Off microphone) Are you going to be there
12 for the health effects subcommittee meeting, too?

13 **MR. ELLIOTT:** I hadn't planned on that, don't know anything
14 about that, so...

15 **DR. ANDERSON:** 'Cause that's the 22nd and 23rd, I think.
16 No, no, it's the 15th and 16th.

17 **MR. ELLIOTT:** No, I had -- I had not planned to participate
18 in the health effects subcommittee.
19 Then on the -- January 2nd of course would be not a good day.

20 **MS. HOMER:** No.

21 **MR. ELLIOTT:** That's coming back from the holiday. And the
22 19th would not be a good day, either. That's a --

1 that's a holiday I'd kind of like to take this time.
2 And then the -- looks like the 26th and 27th would not
3 be good days.

4 **DR. ZIEMER:** Let's start with the week of the 5th then --

5 **MS. HOMER:** Dr. Ziemer, I have leave that week.

6 **DR. ZIEMER:** Okay, that takes care of that week. Let's look
7 at the week of the 12th. So you're out the 12th, 13th,
8 14th --

9 **MR. ELLIOTT:** And 14th.

10 **DR. ZIEMER:** -- and is the 15th a travel day also, then?

11 **MR. ELLIOTT:** No, I'll be coming back on the 14th.

12 **DR. ZIEMER:** We actually -- if we need a, quote, emergency
13 meeting, we're talking about a one-day maximum, I
14 think, so let -- let me ask about the 15th and 16th,
15 are either of those days bad for anyone?

16 **DR. MELIUS:** 16th is a -- may be problematic for me. The
17 15th works, though.

18 **MR. GRIFFON:** 15th is okay.

19 **DR. ZIEMER:** Okay, 15th is a possibility? Let's look at the
20 next week, 19th?

21 **MS. HOMER:** No, somebody couldn't.

22 **DR. ZIEMER:** 19th is a holiday.

1 **DR. MELIUS:** Yeah, the week of the 19th I'm tied up all
2 week.

3 **DR. ZIEMER:** Tied up all week. Others? And remember, we
4 actually only need a quorum, but if possible, we'd like
5 to get everybody there -- 20th through the 23rd are
6 days then when we -- is there any -- are there more
7 than one person not available on those days, and just
8 make a note --

9 **MR. PRESLEY:** I can't be there the 22nd or the 23rd, but I
10 can be there the 20th and the 21st.

11 **MR. ESPINOSA:** I'm out the 23rd.

12 **DR. ZIEMER:** Once we're beyond that, we're almost up to our
13 other meeting, so there's no point in going further.

14 **DR. ANDERSON:** After the 19th, we might as well put it off.

15 **DR. ZIEMER:** Right. As -- there are possibilities, if
16 necessary, 20 and 21, but it looks like perhaps the
17 15th might be the day then. Should we go ahead and
18 block that out? Is that too soon after you get back?

19 **MR. ELLIOTT:** Huh-uh, that's --

20 **DR. ZIEMER:** You're all right? Is that agreeable? That's
21 kind of half-way between --

22 **MS. HOMER:** The 15th is fine for me.

1 DR. ZIEMER: It's fine for counsel or -- okay.

2 MS. MUNN: It's fine for me. I can fly back with Larry on
3 the 14th.

4 DR. ZIEMER: Okay, then let's set aside Thursday the 15th as
5 a special meeting, if needed.

6 MR. PRESLEY: Cincinnati?

7 DR. MELIUS: Are we talking Cincinnati?

8 MS. HOMER: I think that would be best.

9 DR. ZIEMER: Cincinnati's all right?

10 DR. MELIUS: Can we do it like 11:00 to 2:00 or something so
11 people can fly in --

12 DR. ZIEMER: Fly in and fly out? Sure.

13 DR. MELIUS: -- day trip, I think it would also allow I
14 think the --

15 MS. HOMER: Will that be enough time?

16 DR. MELIUS: -- west coast people to get back out.

17 DR. ZIEMER: 11:00 to 2:00 or 11:00 to 3:00?

18 MR. ELLIOTT: Yeah, we can do that.

19 MS. HOMER: Okay.

20 DR. MELIUS: And that would avoid the hotel issue, to some
21 extent.

22 MS. HOMER: Yes.

1 **MS. MUNN:** Only to some extent.

2 **DR. MELIUS:** Where are we going to put --

3 **DR. ZIEMER:** Or it would minimize the --

4 **MS. HOMER:** The Westin.

5 **DR. ZIEMER:** -- overnights, right. And that would be at

6 NIOSH.

7 Okay, is that agreeable? Any objections?

8 (No responses)

9 **DR. ZIEMER:** Okay. So pencil that in. Does the Board wish

10 at this time to also look ahead into the March/April

11 time frame and set aside some dates?

12 **MS. HOMER:** We already have, Dr. Ziemer, for April.

13 **MR. PRESLEY:** I was going to say, we set aside --

14 **DR. ZIEMER:** That's right --

15 **MS. HOMER:** April in Richland.

16 **DR. ZIEMER:** Yes, we --

17 **MS. MUNN:** We have 20, 21, 22.

18 **DR. ZIEMER:** I see it, it's here. Actually we set aside 19

19 through 23, did we -- did we finalize the dates?

20 **MS. HOMER:** No, I haven't.

21 **DR. ZIEMER:** Okay. We sort of --

22 **MS. HOMER:** Yeah, just keep that week open and --

1 **DR. ZIEMER:** So that -- well, I think -- settling on it was
2 going to be dependent on what you could find --

3 **MS. HOMER:** What was available, yes. Wanda and I are
4 working on that right now.

5 **DR. ZIEMER:** Okay. So that basically takes us up to May.
6 That covers the next six months then.

7 Question arose as to the possibility of a Savannah River
8 Site tour. Bob, can you help us -- whether -- how that
9 would be done? Is that something you can help with?

10 **MR. PRESLEY:** Yes. Yeah, the guy that used to be the head
11 of Savannah River is now at Oak Ridge heading up DOE so
12 if y'all want to go to Savannah River, I can call him
13 when I get back and see about a tour, if that's -- if
14 that's what everybody wants, that's up to y'all.

15 **DR. ZIEMER:** Are you okay on that, Ray? I wasn't sure it
16 was -- okay.

17 Let me -- let's get a straw vote here. Board members, how
18 many of you would like to tour the Savannah River Site,
19 show of hands quickly.

20 **MR. PRESLEY:** Now it would have to be on Wednesday the 4th.
21 The tour would have to be before the meeting because
22 we're going to meet the 5th and 6th, so it would have

1 to be on a week day, the 4th.

2 DR. ZIEMER: Show of hands, Savannah River Site tour?

3 (Affirmative responses)

4 DR. ZIEMER: One, two, three, four, I would go if you had it

5 -- I've been there a few times, but you can never see

6 it all, actually.

7 MR. PRESLEY: How many?

8 DR. ZIEMER: Looks like five.

9 MR. PRESLEY: Six, sev-- how many people on the staff?

10 DR. ZIEMER: Looks like another five or so.

11 MR. PRESLEY: So we're talking about 10 to 12 people.

12 DR. ZIEMER: Again, this would be restricted. Right?

13 Spouses --

14 MR. PRESLEY: Yes, sir.

15 DR. ZIEMER: -- could not attend?

16 MR. PRESLEY: Don't know about spouses down there yet.

17 MS. MUNN: Nice boat trip.

18 DR. ZIEMER: You can check on that, perhaps.

19 MR. PRESLEY: Yes.

20 DR. ZIEMER: Okay. Okay, Cori?

21 MS. HOMER: Absolutely.

22 DR. MELIUS: Can I bring up one other issue regarding the

1 meetings? I think the suggestion was made yesterday in
2 public comment period that we have availability
3 sessions or, Larry, you want to call them a public
4 comment session in the evening to accommodate people's
5 work schedule and so forth, can that be arranged for I
6 guess the next two meetings that are on the schedule?

7 **MS. MUNN:** That's rough. That's rough, Jim.

8 **DR. ZIEMER:** I would think it's sort of the Board's call if
9 you want to meet in the evening, is it not? I mean --
10 now we couldn't have done it here 'cause Dave Brenner
11 probably wouldn't give up the auditorium. But if we
12 can find a spot...

13 **MS. MUNN:** Well --

14 **DR. ZIEMER:** Do the Board members object? And we could
15 adjust the meetings so that we didn't go all day and
16 all evening, if you wanted to do that.

17 **MR. ELLIOTT:** We may be -- I'd like to hear the sense of the
18 Board, but we may -- as you think about this, we may be
19 limited in our ability for space. Once we -- we have
20 to contract this with --

21 **DR. ZIEMER:** With the hotel.

22 **MR. ELLIOTT:** -- with the hotel, and given their

1 availability...

2 **DR. ZIEMER:** We could look into that. Also during the
3 public comment period today, if any of those who
4 comment from the public might provide the Board their
5 views on whether you think this would be valuable for
6 members of the public to be able to attend in an
7 evening session as opposed to during the day, why we'd
8 be glad to solicit that input, too. We heard from a
9 speaker yesterday that suggested that that might be a
10 useful thing.

11 There was one other thing suggested yesterday that had to do
12 with making known -- outside of the perhaps the
13 official routes of publishing in the *Federal Register* -
14 - to local people the presence of this Board. For
15 example, it appears that there's not a crowd of Nevada
16 people here at this meeting. And one would say well,
17 what was the advantage then of coming to Nevada if in
18 fact no one from this area attends? And one of the
19 issues is how well do the -- particularly the potential
20 claimants and workers in the area know that we really
21 are here, so we need to be thinking perhaps about how -
22 - are there some other channels to develop that

1 information besides the official channels that are
2 being used in the *Federal Register*, and I know there's
3 a big e-mail list that -- and so on.
4 Now obviously we can't drag people in off -- well, we could
5 drag people in off the street, but -- but at least make
6 sure that certain people know. I mean I -- they may
7 not come anyway, but -- can we think about how that
8 might -- I don't know if you've had a chance since
9 yesterday and maybe the staff --

10 **MS. HOMER:** Dr. Ziemer --

11 **DR. ZIEMER:** -- can think about ways that might be utilized
12 --

13 **MS. HOMER:** -- if I may... previous experience with other
14 committees, and there have been other methods used to
15 announce meetings. For example, a meeting announcement
16 might be prepared and distributed to -- to various news
17 agencies or newspapers, TV stations, things of that
18 nature. I'm not sure exactly how we might go about
19 doing that, but it's certainly been done in the past.
20 I would have to also check into what our options might
21 be in other areas, what -- what methods are being
22 pursued by other committees right now.

1 **DR. ZIEMER:** We had a nice turnout in St. Louis, but I think
2 you'd have to say that that's largely due to the work -
3 - the effort of the local person. Denise made special
4 efforts to get people out. Maybe there are folks at
5 other sites that might be key contact persons that
6 might be helpful. I don't know if others have some
7 ideas that might help here that --

8 **DR. MELIUS:** Can I just comment -- point out that -- not
9 necessarily through any fault of NIOSH staff, but this
10 hotel's had an active picket line up for the last six
11 months by the building trades and therefore I don't
12 think anybody from the building trades, which are most
13 of the people we're talking about Nevada Test Site
14 would come into this hotel to appear, and that's a
15 major -- a major issue.

16 **DR. ZIEMER:** Right. So is there some mechanism for
17 identifying those kind of issues in advance? I'm not -
18 -

19 **MS. HOMER:** Well, when I contact the hotels to make
20 arrangements in the future, I can always ask them if
21 they are a unionized hotel or if there are any other
22 union issues that I need to be aware of. But I have to

1 rely on the information that they provide me with.

2 **DR. ZIEMER:** Okay, thank you.

3 **DR. MELIUS:** I've had discussion with Larry. I think we can
4 provide some additional information. You just happened
5 to pick the one non-union hotel left in Las Vegas, at
6 least near the strip, so -- probably why it was
7 available.

8 **MS. HOMER:** Well, I wasn't aware.

9 **DR. ZIEMER:** Okay. Now any other general comments,
10 housekeeping nature, any other items we need to
11 address? Wanda? Thank you.

12 **MS. MUNN:** I guess one thing I would request in our efforts
13 to better inform the public of our meetings, it would
14 be most helpful I think if in our meeting announcements
15 we mention what we do so that people do not have the
16 mistaken notion that we are an adjudicating body or
17 that we hear individual claims, because I think it's
18 misleading for people to think they may have an
19 opportunity to be speaking to people who will have a
20 bearing on how their claim is viewed, when our
21 responsibility is one of process, not of individual
22 claims. It would be very nice to have more public

1 attention to what we are doing, but at the same time I
2 don't think it's fair if we don't make it very clear to
3 them what it is we are doing.

4 **DR. ZIEMER:** A good point. On the other hand, we need to
5 recognize that the process is within the framework of
6 the individual claims, and sometimes a knowledge of
7 what's happened in individual claims cases helps us
8 understand where the process may or may not be working.

9 **MS. MUNN:** This is true, no question.

10 **DR. ZIEMER:** I think we all recognize that when we hear
11 people relating particular stories, that we are not in
12 a position to act on that particular case, but we may
13 in the process learn something either about the site,
14 about how claims are being handled and processed. So
15 in that sense, I wouldn't want to discourage people who
16 wish to come to the Board with -- and I think most of
17 those who would come to talk to us, with some
18 exceptions, general public individuals, truly in the
19 general public, are people who have claims or are
20 either directly or on behalf of a relative, and who may
21 have concerns that they think that might help us in the
22 process. So in that sense, we don't want to discourage

1 that.

2 **MS. MUNN:** No, that wasn't my intent. No. No.

3 **DR. ZIEMER:** Right. Yes, Henry.

4 **DR. ANDERSON:** I mean one -- one thing that might help is if
5 we were to put out and say we're very interested in
6 hearing about people's experiences with the process and
7 their -- you know, the interviews and -- and paperwork.

8 I mean we heard about paperwork, but that might be the
9 kind of thing to -- 'cause I would assume the people
10 who are interested in coming are those that have filed
11 claims and they want to indicate when they submitted it
12 and how it's been processed. And I think feedback to
13 us as to how --

14 **DR. ZIEMER:** Yeah.

15 **DR. ANDERSON:** -- how --

16 **DR. ZIEMER:** And that's the --

17 **DR. ANDERSON:** -- even though it's going to be a biased
18 sample, I think it is helpful to get a sense of what
19 their perception is and things like that.

20 **DR. ZIEMER:** Yes. Other comments or input on that or other
21 related... And I think, Board members, if any of you
22 have particular ideas on -- or can identify individuals

1 or groups that might be useful to contact at a given
2 location, I'm sure the staff would welcome that. It's
3 -- sometimes it's just a matter -- we can provide the
4 information, but who do we send it to? So if we can
5 help identify those, that would be useful. I assume
6 that's the case, Larry?

7 **MR. ELLIOTT:** Yes, absolutely.

8 **DR. MELIUS:** And if it would -- helpful, at least for me,
9 Cori, if you would let us know as soon as possible
10 about the availability of a room for the evening,
11 'cause that makes some difference in terms of how you
12 outreach to people.

13 **MS. HOMER:** Well, normally the room is available on 24-hour
14 hold by contract. That's how I always set it up. The
15 -- having an evening session will also have to be
16 announced in the *Federal Register*.

17 **DR. MELIUS:** Right.

18 **MS. HOMER:** So that will have to be identified ahead of
19 time, as well. I don't foresee that there'll be any
20 problem having an evening session, as long as we know
21 about it in advance and can announce it.

22 **DR. ZIEMER:** And in fact an evening session could be simply

1 a time devoted for public comment, if necessary. We
2 don't have to conduct other business necessarily.
3 Okay, are there any other items dealing with the Board work
4 schedule or administrative that need to be addressed at
5 this time?

6 **DR. MELIUS:** I have one follow-up to yesterday 'cause I'm
7 not sure what the -- what the plan is. There was the
8 Congressional letter from Quinn, Slaughter and Reynolds
9 to the Advisory Board and --

10 **DR. ZIEMER:** Right, and that letter was addressed to me. As
11 I indicated, I did study it on the plane coming out
12 here. I want to discuss with the Department and
13 perhaps with legal counsel -- some of the things
14 suggested in the letter appear to me to be well
15 outside the charter of this committee, but I need to
16 identify that and I need to prepare a response to -- to
17 those Senators.

18 **DR. MELIUS:** Actually Congressmen, but --

19 **DR. ZIEMER:** Yeah, they were -- three Congressmen, I'm
20 sorry. That's quite correct.

21 **DR. MELIUS:** Can that be shared with the committee then so
22 we --

1 DR. ZIEMER: I'd be glad to do --

2 DR. MELIUS: -- can understand what's going --

3 DR. ZIEMER: I'd be glad to do that, and I think the
4 committee has received copies of that, so you can --
5 you can reflect back to me if you have particular
6 comments to me on that. But I will prepare a letter
7 and that will be made available.

8 **BOARD DISCUSSION/WORKING SESSION**

9 The next item on our agenda is further time for discussion
10 and working session. I think we completed all the
11 items before us. Is there any other item that needs
12 discussion at this time? 'Cause if there is not, I'm
13 going to suggest that we go ahead with public comment,
14 but --

15 DR. MELIUS: Could we talk a little bit about the agenda for
16 the next meeting then?

17 DR. ZIEMER: We could certainly talk about agenda. That
18 would be quite in order.

19 DR. MELIUS: And I --

20 DR. ZIEMER: In fact -- yeah, let's kick that off. There's
21 another workgroup that you're involved with, Jim, and
22 maybe you could suggest --

1 **DR. MELIUS:** I'd say the research group should have a report
2 at the next meeting. I think Henry and I will figure
3 out our schedules finally and maybe on Christmas Day
4 we'll both be home in the office and do that, so
5 research group's --

6 **MR. ELLIOTT:** (Inaudible) Russ?

7 **DR. MELIUS:** Russ, yeah.

8 **DR. ZIEMER:** So the research subcommittee -- certainly be on
9 that agenda.

10 **DR. MELIUS:** I had suggested yesterday that -- requested
11 that Jim Neton or someone give us a presentation on how
12 the site profiles are being used in the individual dose
13 reconstructions, just to walk us through some of that.
14 I think that -- that would --

15 **DR. ZIEMER:** Sounds good.

16 **DR. MELIUS:** At least for me that would be helpful. I don't
17 know if others...

18 **MS. MUNN:** Yes, I agree.

19 **MR. ELLIOTT:** I'm assuming there you would like to see
20 examples of dose reconstruction conducted under the
21 site-wide document, under site-specific type documents
22 with --

1 DR. ZIEMER: Maybe both.

2 MR. ELLIOTT: I'm sure both --

3 DR. MELIUS: Both, both, yeah, yeah.

4 MR. ELLIOTT: -- and see kind of a sampling of those.

5 DR. MELIUS: A sampling of those, but I think -- I'm going
6 to leave it up to your discretion, but it would be I
7 think helpful to look at -- particularly on a -- what I
8 call a complex site, like Savannah River, how that's
9 being used, and then some of the others, with then
10 examples, you know, appropriately masked and so forth
11 from, you know, individuals and what's being done.

12 MR. ELLIOTT: Okay.

13 DR. ZIEMER: Okay, good. Other agenda items that anyone
14 wishes to identify at this time for that meeting?

15 DR. MELIUS: Can we work on -- between now and -- some sort
16 of way of getting moving forward on this possible
17 subcommittee issue, how to --

18 DR. ZIEMER: The answer is -- the answer is yes, and I think
19 I'll -- I'll commit -- and Mark and I have done some --

20 DR. MELIUS: Okay, yeah --

21 DR. ZIEMER: -- some work on that and -- and we'll prepare a
22 -- I think a straw man document for us. I've also

1 asked Cori to provide me with the details on exactly
2 what it takes to set up a subcommittee in terms of the
3 structure and the ground rules.

4 **DR. MELIUS:** Yeah.

5 **DR. ZIEMER:** So we'll provide all of that.

6 **DR. MELIUS:** Good.

7 **DR. ZIEMER:** So --

8 **MR. ELLIOTT:** That could be held under a general agenda item
9 of -- like we have Board discussion and working
10 session, so I won't -- I'll just leave it at that.

11 **DR. ZIEMER:** But make sure -- well, we need to make sure
12 that that's earmarked --

13 **MR. ELLIOTT:** You want a specific agenda item earmarked for
14 that?

15 **DR. ZIEMER:** Let's earmark it so it doesn't fall between the
16 cracks.

17 **MR. ELLIOTT:** So that's --

18 **DR. ZIEMER:** That will remind us --

19 **MR. ELLIOTT:** -- a discussion on subcommittee...

20 **DR. ZIEMER:** This'll be a -- for lack of an exact title
21 right now -- subcommittee on dose reconstruction.
22 Actually it's broader than that, but --

1 DR. MELIUS: Yeah.

2 MR. ELLIOTT: Next meeting --

3 DR. ZIEMER: Subcommittee on dose reconstruction reviews.

4 MR. ELLIOTT: At some point in time in the near future,
5 probably your next meeting, you're going to have to
6 identify, from the pool of completed cases, those that
7 meet your -- your sample --

8 DR. ZIEMER: Right.

9 MR. ELLIOTT: -- for assignment.

10 DR. ZIEMER: Right.

11 MR. GRIFFON: I'm not sure I...

12 DR. ZIEMER: Question?

13 MR. GRIFFON: I mean -- yeah, yeah, we -- there's -- there's
14 quite a few things we probably need to do or the
15 subcommittee needs to do. I don't know that the
16 individual reviews, if there's a large enough pool to
17 sample a lot from right now, but -- but there's also
18 site profile things and -- and other things we can get
19 rolling on.

20 DR. MELIUS: My recollection is that Pete Turcic is supposed
21 to talk next time and -- about the outreach that
22 they're doing?

1 **MR. ELLIOTT:** That is correct, he's made that commitment.

2 **DR. MELIUS:** Okay. Would it -- would a presentation from
3 NIOSH on your outreach sort of complement that and --
4 is that -- does that make -- make sense as a --

5 **DR. ZIEMER:** Put outreach on the budget (sic). Pete will be
6 there representing Labor, and if there's some
7 complementary things that NIOSH could say -- okay,
8 here's what we're doing that complements what Labor is
9 doing, it would be useful.

10 Any other items?

11 (No responses)

12 If in the interim something jumps into your mind that you
13 think we ought to place on the agenda, you can let
14 Larry know or you can let me know, because we'll
15 develop the agenda jointly and -- and then you'll have
16 another opportunity to see the draft agenda. It can
17 always be modified.

18 **DR. MELIUS:** Maybe Ted Katz can present the final SEC regs
19 to -- next time.

20 **DR. ZIEMER:** Am I not correct that the -- well, I won't ask
21 the question.

22 **DR. ANDERSON:** That was rhetorical.

1 DR. ZIEMER: Yeah.

2 MR. GRIFFON: Paul, is there a possibility of -- since by
3 next meeting we're -- all Board members are going to
4 have a copy of the IMBA software, could we have a
5 training session at night? This doesn't have to be on
6 Board time or whatever, but is it possible to arrange -
7 -

8 MR. ELLIOTT: Like we did for NOCTAS?

9 MR. GRIFFON: Yeah, yeah, like a training session.

10 DR. ZIEMER: Well, one of the questions will be can you have
11 a training session at the location of that meeting, and
12 that -- it might be that the training session would
13 more easily be done at the special meeting in
14 Cincinnati.

15 MR. GRIFFON: Yeah, that's true.

16 DR. ZIEMER: So we might -- we might, if it's possible at
17 that time, have some of the Board members -- 'cause we
18 can't -- we're not going to do it all at once as a full
19 Board, but training sessions for individuals who might
20 be available prior or after that meeting, as a
21 possibility. They can -- they can look into it and let
22 us know.

1 **MR. ELLIOTT:** I would offer this. At any point in time a
2 Board member's traveling through Cincinnati and they
3 want to stop by, they want to have an afternoon
4 available to them, we'll give you some training.
5 Right, David?

6 **MR. SUNDIN:** I think I've been volunteered.

7 **DR. ZIEMER:** Provided somebody's there to train us. Thank
8 you.

9 **PUBLIC COMMENT PERIOD**

10 We're a little early for the public comment period, but if
11 the commenters are here -- and I think they are -- and
12 are willing to proceed, first Denise Brock is here from
13 the St. Louis area. And Denise, welcome and please
14 bring us your comments.

15 **MS. BROCK:** Hi, I'm Denise Brock, for the record. I have
16 several questions today, as usual, and some comments
17 I'd like to raise with the Board.

18 First of all, I would again like to say thank you for coming
19 to St. Louis. We really appreciated that.

20 We've had a chance to look at the TBD for the Destrehan
21 Street site, it's been a little bit of time since
22 you've been there, and I would also like to know if

1 there has been any further discussion with the Board
2 about coming back to St. Louis to address that with the
3 claimants. Perhaps we could get a bigger meeting place
4 and maybe more of a crowd this time and have time for
5 Q&A?

6 **MR. ELLIOTT:** The Board has not had that discussion, but at
7 NIOSH there has been a discussion and a -- a plan of --
8 being developed to go around and, as we've done at
9 Savannah River Site last month, as we're getting ready
10 to do at Hanford next -- next month. I can't say today
11 where we're at with regard to the schedule of -- of
12 those site visits, but yes, we do intend to come back
13 to St. Louis and -- and talk about Mallinckrodt.

14 **MS. BROCK:** Wonderful. If -- if there would perhaps be any
15 scheduling conflicts in the near future, if you would
16 consider coming to St. Louis, I would be more than
17 happy to -- to do whatever I could to help you draw in
18 a crowd. I don't have a problem doing that, usually.

19 **MR. ELLIOTT:** We will certainly be contacting you, Denise.

20 **MS. BROCK:** Thank you, Larry. I also understand that there
21 have been some more Mallinckrodt Chemical worker
22 records that have surfaced in Georgia. Are you aware

1 of that or is that something -- I understood that it
2 was just something that happened rather recently and
3 that DOE managed to get ahold of those. Are you aware
4 of that?

5 **DR. ZIEMER:** We'll ask Richard Toohy if he can respond to
6 that question.

7 **DR. TOOHEY:** I'm not aware of DOE coming up with anything,
8 but on one of our data capture trips to the Atlanta
9 National Archives or Federal Record Center, whatever it
10 is, as we routinely go searching through boxes looking
11 for such, we did find some more files on Mallinckrodt.
12 But I honestly don't know what they contained, but
13 they -- they are certainly being reviewed, analyzed and
14 would be incorporated into the Technical Basis Document
15 if there was anything in there that we didn't already
16 know.

17 **MR. ELLIOTT:** We're not aware of anything that DOE has
18 provided on Mallinckrodt at this point, so --

19 **MS. BROCK:** And perhaps --

20 **MR. ELLIOTT:** -- the discovery's been at -- at the benefit
21 of our labor and ORAU's labor.

22 **DR. ZIEMER:** Give credit where credit is due here.

1 **MS. BROCK:** And perhaps that's right, maybe that was a
2 misunderstanding on my part. If I understand
3 correctly, could that possibly be then internal -- or
4 actual individual data on people or -- or site
5 information or both, or you just --

6 **DR. TOOHEY:** I don't know.

7 **MS. BROCK:** You don't know, that's quite all right.

8 **DR. ZIEMER:** I'm sure as that becomes available, it will be
9 incorporated --

10 **MS. BROCK:** It will be added to the TBD then as we -- we go
11 forward. Thank you.

12 And in reference to the Weldon Spring and Hematite
13 facilities, claimants have noticed and commented on the
14 fact that in NIOSH or ORAU correspondence that neither
15 are listed as up and coming site profiles. Is there an
16 expected time line on either one of those? And if so,
17 could you give me an idea of that that is? And we're
18 also somewhat curious, because they are all
19 Mallinckrodt facilities -- I understand that obviously
20 they were different materials that they were working
21 with, but I'm a bit perplexed as to why they don't all
22 get grouped into one, why the TBDs for that one

1 facility are not all done at once.

2 **DR. TOOHEY:** Dick Toohey, ORAU, for the record. Okay, good
3 questions. The -- we did, as a result of the St. Louis
4 meeting, move Weldon Springs up on the list for site
5 profile production, and we expect to be starting on
6 that shortly after the first of the year.

7 The other one, the Hematite facility, I -- I don't think
8 that's on the drawing board. Unfor-- I don't have the
9 list with me, unfortunately, but as always, we try to
10 be responsive to the Board or -- or the public's
11 interest and we can certainly move that up, and
12 especially since, as you mentioned, sites did much the
13 same thing, it should not be too hard to do.

14 **DR. ZIEMER:** Thank you.

15 **MS. BROCK:** And that brings me to my next question or
16 comment, and I think Dr. Toohey -- yeah, just stay; I'm
17 sorry -- Dr. Toohey and I had spoke about this earlier.

18 I've had several situations in where claimants are
19 coming to me with a problem. A lot of times these
20 workers worked not just at one facility, but perhaps
21 two or even sometimes three. And the problem arises --
22 first of all, when perhaps there's a miscommunication

1 somehow or the records are missing, just -- perhaps as
2 Mrs. Ehlmann spoke yesterday, her husband had worked at
3 two facilities and for some reason, even within the
4 same Department, she's getting different stories. And
5 that causes a situation where perhaps if a worker was
6 at the downtown St. Louis site and they are being dose
7 reconstructed as we speak, perhaps that person could be
8 dose reconstructed and compensable before having to
9 wait for further TBDs to even be completed and so I was
10 hoping that perhaps ORAU could take a look at any of
11 the workers or claimants that have worked at more than
12 one facility. And if in fact they were at the downtown
13 site, could they be dose reconstructed just to see if
14 they meet that compensability?

15 **DR. ZIEMER:** Dr. Toohey?

16 **DR. TOOHEY:** Simple answer: Yes.

17 **DR. ZIEMER:** Thank you.

18 **MS. BROCK:** And for the record, I wanted to know if all of
19 the phone interviews in the dose reconstruction for the
20 Destrehan employees -- and that is just for the
21 employees that worked at Destrehan or the St. Louis
22 site -- are those -- are those all completed?

1 **DR. TOOHEY:** I wouldn't say they've all been completed, but
2 as far as I know, all the ones have been completed
3 where the -- we feel the files are ready to move into
4 dose reconstruction. Some of them where people had
5 worked both downtown and also Weldon Springs we kind of
6 put on hold because we didn't have the Weldon Springs
7 site profile done. Others, as we reviewed the files,
8 we find some inconsistency or other problem, say the
9 ICD-9 code doesn't match the cancer diagnosis or the --
10 the employment dates seem to be inconsistent or
11 something like that, and we look at those and try to
12 get that corrected before we actually queue them up for
13 interview and dose reconstruction.

14 **DR. ZIEMER:** Thank you. Further questions or comments,
15 Denise?

16 **MS. BROCK:** Sorry, just a few more. And actually I don't --
17 I don't think any more for Dr. Toohy. One thing that
18 I noticed, and maybe I didn't correctly understand what
19 I read, but I noticed that on the Technical Basis
20 Document or actually on a dose reconstruction, I guess
21 -- it's what it was, it was a dose reconstruction, the
22 Dupree-Ellis -- Elizabeth Dupree-Ellis was cited, and

1 that just alarms me for the simple reason -- I guess
2 this is a comment -- that she completely excluded
3 internal dose, and I felt like she grossly
4 underestimated things. I just wanted to make that
5 comment.

6 And I don't know if I can do this. I wanted to ask a
7 question of Dr. John -- is it Moreau?

8 **UNIDENTIFIED:** Mauro.

9 **MS. BROCK:** Mauro? And I don't know -- can I ask it? I
10 guess you won't necessarily be able to --

11 **DR. ZIEMER:** Depends on the question.

12 **MS. BROCK:** Okay, can I say it to the Board, say yea or nay,
13 either one?

14 In reference to off-site exposure, Hematite, Weldon Spring
15 and St. Louis I understand had a lot of residual
16 radioactivity or ground water problems, air problems,
17 things such as that. And I was curious if a member of
18 the public could request Sanford Cohen & Associates to
19 look into that? Like there's a situation in Hematite
20 where there's residual radiation. The Department of
21 Energy doesn't want the responsibility to clean this up
22 because they're saying there was a problem with nuclear

1 subs. Everybody passes the buck and so nobody wants to
2 clean up this mess. And I'm wondering how that can be
3 addressed or how would I go about that and if that's
4 something that they're able to handle.

5 **DR. ZIEMER:** It seems to -- it seems to me that in terms of
6 their role with the Board that that could certainly be
7 inappropriate, but that's something the legal folks
8 would have to address.

9 **MR. ELLIOTT:** As a member of the public, you're -- the
10 contract with Sanford Cohen & Associates is with the
11 Board as a government entity, and they're given a
12 specific charge, a specific scope of work that they're
13 proposing against. And what you're asking for is not
14 included in that scope.

15 **MS. BROCK:** So find other health physicists. Right?
16 Basically.

17 **MR. ELLIOTT:** And you'd have to have the money to support
18 that -- that effort.

19 **MS. BROCK:** Right, or maybe attorneys would, I'm assuming,
20 because I think that's what a situation was in another
21 area, too.

22 Let's see. And another comment was, in reference to dose

1 reconstruction, in or with the absence of datas (sic),
2 I understand that there is to be the surrogate coworker
3 data and the use of site profiles are extrapolation.
4 My concern is, again, how do you know that these datas
5 are -- you're using are not -- are even accurate?
6 There is a distinct probability -- at least in the case
7 of Mallinckrodt -- that there was altering or coverup
8 of datas or numbers, if you will. And again, back to
9 those badges, I -- I understand that somebody was
10 referencing to badges; I think that was Dr. John -- I'm
11 sorry, Morau, Moreau --

12 **UNIDENTIFIED:** (Inaudible)

13 **MS. BROCK:** -- yeah, okay, Mauro, and I -- I've heard
14 repeatedly from workers that these badges were useless,
15 and it just is a grave concern of mine that when
16 somebody's looking at a badge and you have two workers
17 working side by side and one comes -- comes up red hot
18 and the other comes up with a big fat nothing, and when
19 you go in there to try to dose reconstruct these people
20 and that badge is coming up with no reading, that is a
21 big concern to me and I'm really afraid that when you
22 use those sort of readings, I don't know how you can be

1 so sure that the datas are accurate, and I guess that's
2 my comment. Thank you.

3 **DR. ZIEMER:** Thank you, Denise. Let me ask if any Board
4 members have questions. Yes, Jim?

5 **DR. MELIUS:** I have a follow-up question -- I think it's for
6 Dick -- but based on what Denise asked, though. But is
7 the -- for the site profiles, is there a schedule of
8 those site profiles, a sort of a listing --

9 **DR. TOOHEY:** Yes.

10 **DR. MELIUS:** -- on the web site with an estimated --

11 **DR. TOOHEY:** It's not on the web site, but we supplied it to
12 NIOSH, so I --

13 **DR. MELIUS:** Would it be possible to put on --

14 **DR. TOOHEY:** -- could get it --

15 **DR. MELIUS:** -- my -- I guess my question is would it be
16 possible to put that on the web site so that people
17 would, you know, have a way of knowing sort of what the
18 schedule is and -- and you know, possi-- it doesn't --
19 doesn't have to be, you know, exact, but estimated
20 spring of whatever, something like that or --

21 **MR. ELLIOTT:** We'll --

22 **DR. MELIUS:** -- (Inaudible) subparts are.

1 **MR. ELLIOTT:** We'll consider that. I can't give a guarantee
2 today, but we'll consider that. This is a -- this is a
3 plan that's being reviewed and evaluated right now for
4 its feasibility and its realisticness -- if that's a
5 word -- realism, I guess -- can we achieve it, so we're
6 working toward that.

7 **DR. MELIUS:** No, and I think if it -- once it's -- the plan
8 is finalized, that's the point I think it might be
9 helpful for the public to be able to see, you know,
10 what you're -- you're planning on doing before it gets
11 all...

12 **DR. TOOHEY:** Can I make another comment, possibly partial
13 answer to Denise's last one on accuracy of coworker
14 data or badge readings or anything? I would just like
15 to mention -- don't forget, every dose reconstruction
16 we do contains an estimate of the uncertainty in that
17 value. And many times that uncertainty can be very
18 large. And then that gets run through the IREP program
19 in the uncertainty on the probability of causation.
20 And since we're at the 99 percent confidence interval
21 for the decision criteria, a lot of the errors or
22 inaccuracy in the point estimates that we get in the

1 workers are accounted for by including the uncertainty
2 in those values.

3 **DR. ZIEMER:** And many people don't realize that in most
4 cases, larger uncertainties help the claimant because
5 it spreads that distribution out more. It's one of the
6 exercises I have my students do. They -- I give them
7 some hypothetical problems to solve with IREP and to
8 look at the effect of uncertainty on the award or on
9 the probability of causation. Generally it tends to
10 favor the claimant, the more uncertain that information
11 is.

12 Our next speaker from the public is Richard Miller.

13 Richard, welcome. Richard's with the Government
14 Accountability Project.

15 **MR. MILLER:** Richard Miller, for the record. Good morning.

16 I guess with respect to the schedule and agenda, I'd
17 like to offer a plea for you to enjoy the lake effect
18 off of Buffalo at some point. I think that there's
19 enough interest in what's going on in western New York
20 that I know there's probably going to be some other
21 efforts to communicate with people up there. But there
22 seems to be an awful lot of interest in the work of

1 NIOSH and the Advisory Board, and I think --
2 notwithstanding the delightful climate there, I think
3 that might be worth looking at as a potential future
4 location. There's certainly plenty of people I think
5 would be happy to cooperate with the Board and NIOSH
6 and in having either evening sessions or outreach
7 activity to ensure a full and robust participation,
8 given that it has one of the largest concentrations of
9 facilities in the country.

10 Second suggestion is -- is -- well, let me just -- as a
11 footnote to that, I think it would be helpful to have
12 some discussion about whether and if the Board or what
13 policy the Board will address if people want to get a
14 site profile reviewed. You -- Dr. Melius raised one
15 letter that just came in from three members of
16 Congress, and Dr. Ziemer said something to the effect
17 of well, these are legal issues and I'll respond. But
18 I -- I think there's a broader question here, which is
19 you've got -- as you develop these site profiles and in
20 those sites where there's some, you know, concentrated
21 community interest -- certainly like St. Louis -- it
22 wouldn't surprise me if you'll see more than one of

1 these come forward because the audit process is in fact
2 the only check and balance on this program in -- in --
3 within the program's boundaries itself. I mean there's
4 other checks and balances in government, but this is
5 the -- the design of the program. And so, you know, I
6 was sort of looking at -- at John Mauro's presentation
7 and there was -- I saw there was like ten to 12, you
8 know, DOE sites and four -- two to four AWEs, I'm
9 thinking two to four AWEs, hmmm, well, what happens if
10 you get six letters from six Congressional areas, you
11 know, or districts or facilities wanting you to do site
12 profile reviews? What do you say to them? Too busy,
13 come back next year? Legally we can't take your
14 request? I mean I don't know what the answer's going
15 to be, but it seems to me there's -- there's probably
16 an opportunity here for some -- for some policy
17 development about what the Board takes in in terms of
18 these kinds of inputs and then how do they get resolved
19 and addressed -- or prioritized, for that matter? I
20 mean you could spend all your time looking at uranium
21 facilities and -- and miss Hanford and Savannah River
22 in your site profile reviews, and so part of it may be

1 an allocation of resource issues. But I think that --
2 but on the other hand, I think there's this intense
3 public interest and obviously Congress is an important
4 stakeholder in all of this -- this program, as well.
5 And I just -- I just think that given, you know, this -
6 - this -- the program is now ripening to the point
7 where the audit function's going to start to take on,
8 you know, flesh and bones and a real activity, that it
9 would be very helpful -- 'cause I don't think this is
10 something that ought to be dressed simply as a legal
11 question. I think it's a policy question at large, so
12 that's just my suggestion to the Board. You all think
13 about how you want to address that. I have my own
14 thoughts on that, but I don't know that this is the
15 time to do it.

16 The third question is -- has to do with Blockson Chemical.

17 This is now the third time I've raised Blockson
18 Chemical and I know that NIOSH and the Secretary of
19 Health and Human Services haven't asked for the Board's
20 opinion on Blockson Chemical, but I'm going to see if I
21 can't spur you all to kind of stick your nose into this
22 a little bit, 'cause it's a really interesting what I

1 think is policy question. Again, I don't think it's a
2 legal question alone. And that has to do with whether
3 or not you include, and how much of this chain of
4 production you include, of radon exposure at these
5 uranium phosphate facilities that were used for -- I
6 mean -- I mean rock phosphate facilities that were used
7 for uranium extraction.

8 And the -- the -- oh, dear, I apologize. And I guess the
9 thing that -- the thing that is interesting is --
10 excuse me, I thought I turned that off -- that's
11 somebody else's. I don't know.

12 That -- the Blockson Chemical issue -- I don't know, has
13 anybody had a chance or -- just to the extent you have
14 had a chance to look at the Blockson Chemical report,
15 you'll see in there there's a section on radon which
16 says reserved, so -- and -- and claimants have been in
17 touch with me and I've had the pleasure of chatting
18 with a number of people in the Joliet, Illinois area
19 who have received their dose reconstruction reports.
20 They have not been sent to DOL for adjudication.
21 They're being held in abeyance at this point. And the
22 question is, where along the food chain of this -- of

1 the intake of the rock phosphate through to the
2 production of phosphoric acid and through the various
3 precipitating processes and oxidation processes and
4 through to the final uranium process and -- and so
5 forth, do you or do you not include radon exposure?
6 And I am aware that there are a variety and a diverse
7 set of views because just like Gaul, this program is
8 divided into three Federal agencies and -- and here I
9 think each of the agencies may even have their own
10 views on this subject. But it is as much a policy call
11 about where you draw the boundaries around what
12 constitutes attributable radiation exposure for
13 purposes of this program as it is whatever some lawyers
14 decide to concoct. And the reason I say that is,
15 having had a chance to review the contract between the
16 Atomic Energy Commission and Blockson Chemical, they
17 purchased it by the pound. And so they wound up with a
18 purchase of all of the inputs from the raw phos-- rock
19 phosphate coming in from Florida all the way through
20 until the uranium was extracted. And so the economic
21 transaction would argue for a broad encompassing
22 approach to including the radon exposure. And there

1 are other ways of slicing this would say but wait a
2 minute, that rock phosphate also came in and was used
3 to make trisodium phosphate, Tide detergent, and should
4 the program be compensating people for making Tide.
5 Right? I mean you could -- you could make that
6 argument.

7 And on the other perspective, one could say well, maybe
8 there's a middle ground to be carved out here and --
9 and we can find some sort of discrete spot to carve it
10 out because this was a multi-purpose facility. You
11 could also argue that this facility's economic life was
12 substantially extended and bolstered because they ma--
13 they did this uranium extraction, and it was a very
14 lucrative contract for Blockson Chemical. And -- and
15 but for this contract existed, that facility existed in
16 -- in economically turbulent times when the fertilizer
17 industry was definitely on the bottom of the commodity
18 cycle. So there's a lot of ways to debate this
19 question. I'm not here to present every single one of
20 those choice points.

21 I guess all I'm floating is that I think this is an item
22 which is also ripe for Board consideration. Now that

1 doesn't mean that NIOSH is inviting your comment or
2 even interested in your comment. But at the end of the
3 day, I don't see how the Board can not look at this
4 kind of question, because at the end of the day, you're
5 going to be auditing it and these are generic issues to
6 numerous phosphate to uranium processes. This isn't
7 the only plant, as many of you know. So I just thought
8 I would add that to your list of items where a
9 deliberative process -- you could review the
10 engineering reports. NIOSH I think has done an elegant
11 job of laying out in the site profile the production
12 process, so you could at least see it, maybe see the
13 source documents, the contracts, and begin to grapple
14 with this to figure out where do you draw the line.
15 Otherwise, I think that -- that this is going to get
16 decided behind closed doors. You're going to be left
17 auditing something where it's going to be preordained
18 whether or not you get to even examine that dose
19 because the agencies have prejudged it. And I think
20 what -- there's an ongoing deliberative process now. I
21 don't think -- I don't know, Larry, maybe you can --
22 I'm prepared to stand corrected here, but I don't

1 believe that issue is fully closed, at least as of last
2 week, so I just thought I'd lay that out as a -- a
3 topic where I think your expertise in combination here
4 would be really valuable.

5 Am I to prepare to stand corrected, Larry?

6 **MR. ELLIOTT:** I have no comment.

7 **MR. MILLER:** Well, that gives you a flavor, unfortunately.

8 Next item I'd like to put on the plate for the Board, I
9 guess -- again, and -- and for NIOSH, it's just a
10 suggestion that a policy be developed with respect to
11 professional standards -- conflict of interest I guess
12 is sometimes too narrow a term, but it -- we've all
13 used it in shorthand here to cover the broad
14 professional standards of -- of -- of -- that are
15 expected here, that go well beyond financial conflict.

16 And -- and -- and I just can't help but observe that
17 it seems like almost every meeting we have kind of a
18 dandelion coming up in the lawn of another conflict of
19 interest sprouting. And it seems like it's largely
20 attributable and -- and frankly, fortunately, that
21 NIOSH was willing to provide some transparency on who's
22 working on these teams, but people seem to be

1 identifying these things for you, and it seems to me
2 this ought to be a Federal agency function up front.
3 They ought to be combing through this issue up front
4 and the public serves as a check and balance, rather
5 than the public serves as the only policeman for these
6 professional standards questions. And so I would just
7 urge you all to -- to think very hard about whether you
8 want to revisit this. As Jim Melius noted at the --
9 yesterday's meeting, in a way, a lot of us sort of
10 thought the site profiles would accumulate the value of
11 the knowledge of each individual dose reconstruction,
12 and so the site profile and the conflict of interest
13 issue really didn't ripen until -- as this program
14 ripened. And I think it's worth re-examining.
15 Otherwise we've kind of locked ourselves in to only
16 looking at dose reconstruction and -- and -- and -- and
17 not the site profile, and it may be the very fertile,
18 raw material out of which each of the cookie-cutter
19 dose reconstructions in some cases are going to be
20 extracted. So I just would encourage you all to
21 rethink whether it's maybe time to have a
22 recommendation to NIOSH in a formal way urging some

1 kind of conflict of interest provisions which mirror
2 those that are used by Dr. Toohey and others at Oak
3 Ridge Associated Universities on the dose
4 reconstruction conflicts. I just -- I don't know how
5 many more of these you want to have sprout up before
6 you finally take Board recommendation in this area.
7 I would just offer this with respect to the evening meeting
8 question. I think it varies. I think it goes from
9 site to site. If you've got well-organized claimants
10 or well-organized institutions that can help you do it,
11 you know, it's where you are. Right? I mean I think
12 there'll be lots of volunteers in western New York and,
13 you know, maybe you'll have them, maybe you won't have
14 them. And I think it ought to be -- I think you ought
15 to figure out in advance -- if you're going to schedule
16 an evening meeting, figure out if it's going to be
17 productive -- right? -- and -- and not just do it and
18 then have an empty room and sit there for two hours and
19 close the record. So -- and I'm certainly happy to
20 help NIOSH network with people where they're not
21 already plugged in. And I'm sure there are others on
22 and off the Board that would be delighted to do so

1 because I think it would be immensely productive and it
2 would also promote greater understanding. I think
3 there needs to be a two-way communication on this
4 'cause it's complicated.

5 Finally, I would just propose -- probably for the last time
6 I'll raise it publicly, here at least -- but I -- I
7 have -- will -- will sort of -- I guess raise the
8 question -- I'm delighted that the Board is going to be
9 -- apparently going to get trained and learn to use
10 IMBA and all of those good things and -- and -- and I
11 was delighted to read that if you want to go to
12 Cincinnati, you can, even as a member of the public,
13 have an opportunity to use IMBA. I -- I think there
14 need to be some creative solutions to dealing with the
15 proprietary software issue. I don't know how much
16 creativity's been applied to it at this point, or maybe
17 there's a way your support service con-- you know, Oak
18 Ridge, could provide some kind of service so that if
19 you don't want to provide proprietary software, at
20 least you can make somebody available who can, for
21 members of the public, make use of IMBA and IMBA
22 outputs. It's -- it's a very difficult thing to take a

1 blank site profile which are where the doses are
2 conveyed and -- particularly the internals are conveyed
3 and, you know, DPMS or whatever with solubilities
4 identified and -- and be able to replicate the results
5 that NIOSH is providing to individual claimants. And -
6 - but more particularly, it becomes more important as
7 you get into things like extrapolation where you don't
8 have data and -- and I -- I would just encourage you
9 all to think about whether it makes sense to have a
10 program relying on proprietary dose reconstruction
11 software where it effectively is inaccessible to the
12 public except in the most -- except with a very high
13 barrier, meaning that -- that the price tag for
14 interacting with NIOSH or with this program or even
15 this Board at a technical level is ponying up some six
16 figures or five or six figures to get access to
17 software. And -- and I -- I know I -- I respect that,
18 you know, people are in the business of making money on
19 their software programs, but you've got a public
20 program here -- public compensation program relying on
21 private software. And it -- it -- it -- I think it
22 poses a transparency question and I would hope that you

1 all would -- once again, I'm revisiting this now for
2 the third time; as I say, it will be the last time I
3 revisit it here -- but I -- I -- I just think you've
4 got a problem assuring transparency throughout, and
5 this is a huge obstacle in that transparency, so I
6 would encourage some thought to that. Thank you.

7 **DR. ZIEMER:** Thankful -- or thank you, Richard, for your
8 thoughtful comments. Let's take a minute and see if
9 Board members have questions to pose to you relative to
10 your remarks. Any?

11 **DR. MELIUS:** Yeah, I have one question and I -- for both I
12 guess Larry and Richard, and that's the Blockson
13 Chemical -- if I understand that correctly -- and I
14 don't understand it completely, but what's an issue --
15 more of a generic issue with a number of the AEC sites
16 in particular where there's a sort of a commercial use
17 and a -- commercial exposures or exposures from other
18 industrial process as well as from the AEC process, and
19 the issue is how you parse the exposures and do them,
20 and I -- and I don't understand to what extent it's
21 policy, legal or whatever, but I think certainly a
22 briefing on that would -- at some point soon would be

1 very helpful to the Board so at least we understand
2 what -- what's involved in the decision-making, as well
3 as how it will affect future dose reconstructions,
4 so...

5 **DR. ZIEMER:** And Richard also entered into the public record
6 some related comments. I think the Board members have
7 gotten copies of your written comments on that Biloxi
8 issue, Richard.

9 Let me ask a somewhat related question. Does this revolve
10 around the official definition of -- of the facility
11 insofar as it relates to weapons production?

12 **MR. MILLER:** You know what, it's like lawyers say, it
13 depends who you ask.

14 **DR. ZIEMER:** Well, but -- but that -- that lies at the crux
15 of it, as the starting point that it's defined in a
16 certain way and then that gets interpreted. Well,
17 where is that line exactly? Does it cover this -- the
18 -- clearly there's radon related to the phosphate
19 thing. I know -- I see Dr. Roessler here, who worked
20 with phosphates a lot down in Florida and very much
21 aware of the radon issues, but then the issue is where
22 -- where does that end as far as what that company was

1 doing anyway and where does the -- the uranium work
2 begin and were the uranium workers also exposed and is
3 this part of their occupational exposure. That's --

4 **MR. MILLER:** It's a great set of questions, Dr. Ziemer,
5 and it's --

6 **DR. ZIEMER:** Yeah, I --

7 **MR. MILLER:** Well, go ahead. I mean -- I didn't mean to cut
8 you off.

9 **DR. ZIEMER:** Well, and I think Jim is saying we -- we don't
10 necessarily know what all those issues are, either. I
11 understand that perhaps NIOSH has itself been
12 addressing that or looking at that, and I don't know if
13 you want to make any comments on that, but that's
14 certainly been part of the issue. You're -- you're
15 perhaps questioning whether or not the decision has
16 been made and is fixed in concrete, and it may affect
17 other facilities, as well. Is that --

18 **MR. MILLER:** Well, I think there's several things. I mean I
19 -- I don't know what the final status of the
20 interagency deliberations are in this. I know there's
21 certainly some options and comments that have been
22 circulated. I guess the question is, let's leave aside

1 the interagency debates for a moment and just step back
2 by bringing to the fore what actually this Board
3 brings, which is a remarkable rich diversity of
4 expertise, and ask the question -- assuming that an
5 atomic weapons employer facility lawfully encompasses a
6 facility, broadly defined, and you're looking at the
7 production of materials that are ultimately used for a
8 nuclear weapons program where you have this dual-use
9 issue -- right? -- commercial and non -- and non --
10 military and non-military, we'll say, or DOE and non-
11 DOE -- where you then have to ask the question where it
12 may even be inseparable, and let's assume that legally
13 you can look at the whole thing. And then let's say
14 okay, where does it make sense to tease it out? In
15 other words, can we apply common sense to this
16 question, 'cause it's a thought puzzle, I think. It's
17 a thought puzzle. I mean -- you know, having sat down
18 and kind of sketched out about five options, I could
19 persuasively -- to myself, at least -- argue five
20 different ways to draw the line on this thing. But in
21 fact it's a -- partly a health physics question and
22 it's partly a engineering question and it's partly a

1 policy call about how you deal with the equities for
2 individuals, and it is -- I mean -- and -- and one
3 could just -- I mean the myriad of equity issues just
4 jump out at you. Right? Well, the -- so the person
5 who makes rock phosphate and gets radon exp-- you know,
6 processes this into phosphoric acid and they have radon
7 exposures but they make Tide and they're not
8 compensable, but the individuals who -- who make -- who
9 -- who are part of the -- how do you even parse it out
10 because the same person's making it for both -- both
11 production chains. I don't have the -- the ri-- in
12 other words, I'm not here advocating a particular
13 solution, but I do think the options ought to be
14 fleshed out because it's -- it is so important to the
15 equities about whether or not you attribute dose that
16 is at lea-- least partially attributable to the work
17 that you're doing that wound up as part of this
18 company's work for the Atomic Energy Commission or not.

19 And it's not so remote that it's laughable. Right?
20 It's just -- it's an equity issue. It's -- It's a
21 Solomon-like activity, where are you going to divide
22 the baby? And I think reasonable people could differ

1 on this thing, but I think it ought to be aired out and
2 -- and I think it ought not be decided simply in an
3 interagency deliberation process. Or to the extent it
4 is, at least it would be useful if the perspectives of
5 this Board were also informing the thinking of the
6 Federal -- Federally-responsible officials in this
7 respect. That -- that's sort of my pitch.

8 **DR. ZIEMER:** Thank you.

9 **MR. MILLER:** Let me -- let me just -- just add one last
10 thing, which is -- is -- is -- is since poor Larry
11 often seems like my -- my good friend Eeyore who -- who
12 -- who dreads coming to these meetings and -- and looks
13 very unhappy most of the time, and I want to say
14 something nice for Larry for a change, before I say
15 something else, and -- so you can get off your pins and
16 needles now. I found -- NIOSH's work on the site
17 profile at Mallinckrodt begs numerous questions.
18 Denise raised terrific questions, and I have them, as
19 well. How are you going to deal with the periods of
20 time where you don't have good dose information or any
21 dose information, and how can we have any confidence
22 that we're not estimating -- underestimating the

1 periods where you don't have dose data, and
2 particularly when you're relying on, you know, 50-year-
3 old methods of analysis. But in the course of the site
4 profile, I found a terrific footnote for a document
5 that at least I had been looking for for over a year,
6 diligently, with numerous requests all over the place,
7 by Merril Eisenbud and had -- was very pleased to see
8 that it was footnoted in the site profile, and -- and
9 in this Eisenbud document -- I don't know if the Board
10 has had a chance to look at it, but it was the basis
11 for an article that ran in the *Riverfront Times*, it's -
12 - it's called an estimate of cumulative multiple
13 exposures to radioactive materials at Mallinckrodt's
14 plants four and six from November of 1950. What was
15 stunning, in addition to the level of doses that were
16 estimated for a typical worker in the matrix that was
17 used, which was about 1,000 rem to the lung over about
18 a two-and-a-half-year period, was -- was the -- and
19 this formerly secret memo said, and it just -- just to
20 tickle your fancy, it -- it -- if I could just read one
21 paragraph to you, it says here (reading) Early in 1947
22 the New York operations office evaluated the potential

1 hazards in these plants and, after finding it to be
2 considerable, recommended the necessary corrective
3 actions. In addition, steps were taken by NYOO in
4 cooperation with the contractor to institute procedures
5 for effective environmental and personal monitoring.
6 It was recognized that pending elimination of excessive
7 exposures, here was a unique opportunity to conduct
8 clinical studies on a fairly large-sized population
9 whose radiation exposure for several years had been
10 considerably in excess of any group for which data was
11 available.

12 And I just have to say that this really was a remarkable
13 window in a candid memo about the perspectives that
14 were in place at least at that time about how
15 convenient it was to study the workers at Mallinckrodt
16 without regard to how they were put in harm's way. And
17 that really was the foundation of a lot of what
18 informed the passage of this law. And every now and
19 then these -- these -- these remarkable historical
20 documents finally see their way to light and -- and I
21 just would like to thank NIOSH for making sure that
22 this one found its way to light and -- and they

1 produced it without need for a FOIA request and did so
2 in a transparent way. And so I just wanted to express
3 that appreciation.

4 **DR. ZIEMER:** Thank you. Thank you, Larry -- or thank you,
5 Richard. Thank you both.

6 Okay, that concludes our public comment requests.

7 **MS. BROCK:** (Off microphone) Dr. Ziemer --

8 **MR. ELLIOTT:** She's thought of something.

9 **MS. BROCK:** -- (Off microphone) can I make one more comment?

10 **DR. ZIEMER:** Yes, you may. Denise Brock.

11 **MS. BROCK:** I forgot to mention earlier, I -- in reference
12 to what Cori and -- and Larry, I believe, were talking
13 about how to alert people or media. I actually had a
14 list recently that I used that actually listed all of
15 the papers -- suburban journals, any paper that I could
16 come up with through the state of Missouri and through
17 Illinois, as well as the -- the news channels and the
18 radios, and I sent letters out to each and every one of
19 them actually looking for any of the 3,300 employees of
20 Mallinckrodt or anybody involved in the building and
21 construction trades. And I've gotten a lot of response
22 from these papers saying that they are going to run ads

1 looking for -- for people that worked at these
2 facilities.

3 I was also contacted by some people in Illinois who are
4 wanting me to come there to help them organize and kind
5 of do what we did for the Mallinckrodt site, so I'm
6 going to do that, as well.

7 But I was curious if it's ever possible to do like a public
8 service announcement, if that's possible, to put
9 something like that on TV and maybe just try to get
10 contact people in each area to alert claimants or to
11 try to -- and I think that's probably part of the
12 outreach with the Department of Labor, as well.

13 **DR. ZIEMER:** Thank you. That's very helpful. We then are
14 at the end of our open business session. Let me ask if
15 any of the Board members have any additional items or
16 comments for the good of the order? 'Cause if they
17 don't, we are going to adjourn the public session. We
18 will take our lunch break a little early. I think we
19 probably -- well, in fact they do need to clear this
20 room out anyway and prepare it for the big show
21 tonight, so you need to get all of your stuff out of
22 here.

1 We will reconvene at 2:00 o'clock in the Mesquite I Room --
2 the Mesquite I Room at 2:00 o'clock. I will, for the
3 record, again emphasize that this is a session that is
4 only for the discussion of the task orders and the
5 independent government cost estimate. The Board will
6 do no other business at that meeting.

7 We now stand adjourned as far as the public meeting is
8 concerned. Thank you very much.

9 (Whereupon, the public portion of the meeting was
10 adjourned.)

