

1 different time, and here it is. And so I think
2 maybe we will have some comments on this -- or
3 some discussion about this. Issue number seven
4 relates to a suggestion that organically bound
5 tritium at Savannah River would produce a
6 significantly higher dose than tritiated water
7 (unintelligible) tritium, which is essentially
8 the assumption in the dose calculation for
9 Savannah River.

10 Our position, first of all -- well, there's --
11 there's another issue. Our -- this is -- this
12 particular issue relates to a tritiated organic
13 compound, and I think the most logical thing
14 that comes to mind is a lubricating oil or
15 something like that that would be contaminated.
16 You would have a tritiated organic compound.
17 It certainly seems from what we've seen is that
18 the vast majority of the tritium at Savannah
19 River was tritiated water, and that by using
20 tritiated water as the basis for the dose
21 calculation, particularly when you look at the
22 way the doses are -- are done, I mean we
23 generally don't do a -- a specific intake and a
24 dose calculation. We'll say how high could the
25 dose have been this year and not shown up on

1 the bioassay record, and that's what we're
2 going to assign. We think that the approach
3 we've taken of assuming tritiated water is the
4 appropriate approach to take because of the --
5 the majority of the tritium at Savannah River
6 was tritiated water. We -- we do make a
7 comment that the -- the dose of -- the dose
8 from organically bound tritium is only about
9 twice of what it is from tritiated water rather
10 than four times. I believe -- Hans, I believe,
11 agrees with that.

12 But -- but despite that, we still believe that
13 the approach we're taking is correct because of
14 the preponderance of tritiated water versus
15 organic form.

16 **MR. FITZGERALD:** Let me make a comment here.
17 This is Joe Fitzgerald. We're in the midst of
18 the Savannah River site profile review and this
19 is obviously one of the areas that's being
20 reviewed in a generic sense for the site
21 review. And I'm not sure if it would not be a
22 better idea to see how that characterization
23 worked, that review of dose, and perhaps in
24 that exchange deal with the more generic
25 question of trying to characterize the -- you

1 know, how that's being addressed rather than
2 trying to nail it here.

3 **DR. H. BEHLING:** We tried that -- this is Hans
4 Behling. We tried to -- to come to that
5 conclusion earlier on, but I think Mark wanted
6 to at least bring it up --

7 **MR. FITZGERALD:** Well, the reason I'm raising
8 it is because I know talking to Kathy DeMers,
9 this is something that she's going through
10 quite a bit of documentation right now and I
11 know she wants to talk to you all about it and
12 try to work this out, so I --

13 **DR. H. BEHLING:** You have no arguments with me.
14 This is Hans Behling.

15 **MR. FITZGERALD:** This is what -- this is
16 certainly a key characterization issue. I
17 think it's a legitimate question. I think
18 NIOSH has a very valid point and I think we're
19 in the midst of trying to work this thing --
20 it's going to be within the next 30 to 60 days,
21 so it's not like we're -- we're
22 (unintelligible) most and -- and --

23 **MR. GRIFFON:** I -- I --

24 **MR. FITZGERALD:** Go ahead.

25 **MR. GRIFFON:** I -- I just wanted to

1 (unintelligible) issue. I think that part of
2 this resolution might come through the site
3 profile (unintelligible) --

4 **MR. FITZGERALD:** Yeah (unintelligible) --

5 **MR. HINNEFELD:** I think by -- you know, we
6 agreed to -- Hans and I originally, off line,
7 thought why don't we just defer it to the
8 Technical Basis discussion because it'll come
9 up there. It'll be discussed there. We said
10 well, we want to have some discussion of the
11 issue, at least frame the issue --

12 **MR. FITZGERALD:** Yeah, that's fine.

13 **MR. HINNEFELD:** -- and -- but with the perfect
14 understanding that we're not going to resolve
15 that here, and we -- and it's our intent to add
16 that onto --

17 **MR. FITZGERALD:** Okay, well, that's fine.

18 **MR. HINNEFELD:** Yeah, that's fine, if that's
19 acceptable to everybody.

20 **MR. GRIFFON:** (Unintelligible)

21 **MR. HINNEFELD:** (Unintelligible) that, I think,
22 at Savannah River is probably relatively minor.
23 Other facilities, metal (unintelligible), as I
24 understand it, represent sort of a thorny issue
25 and right now I don't know what I want to --

1 what I would say about that.

2 **MR. GRIFFON:** Well, you -- you -- I mean even
3 af-- even after that, I'm sure you have a
4 (unintelligible) you know --

5 **THE COURT REPORTER:** It's hard to hear you,
6 Mark.

7 **MR. GRIFFON:** Sorry. Even at Savannah River I
8 imagine you have a potential for some metal
9 (unintelligible) just from the (unintelligible)
10 equipment, rust and perhaps other things or --
11 you know, just like your organic from the oils,
12 but I -- I -- I don't think, you know -- I
13 think we would defer that also to the site
14 profile review process, but --

15 **MR. HINNEFELD:** Well, that would be -- I think
16 we're going to have to. I don't think we're
17 going to ever resolve it here today --

18 **MR. GRIFFON:** Yeah, I agree (unintelligible) --

19 **MR. HINNEFELD:** -- (unintelligible) issues
20 being pursued in that -- that arena. But you
21 know, I'm all for that.

22 **MR. FITZGERALD:** And this discussion really is
23 helpful. I think it's going to help --

24 **THE COURT REPORTER:** Who is this?

25 **MR. FITZGERALD:** -- when we discuss -- when we

1 get to --

2 **THE COURT REPORTER:** Who is this?

3 **MR. FITZGERALD:** Oh --

4 **MR. HINNEFELD:** That was Joe.

5 **MR. FITZGERALD:** Oh, I'm sorry. Yeah, this
6 discussion will be very pertinent. It will
7 lead into a lot of what we're doing already in
8 the profile review so it -- it's certainly
9 helpful, anyway.

10 **DR. H. BEHLING:** I think we can therefore
11 conclude, based on what we stated here, that in
12 the final draft of this 20-case review we're
13 going to eliminate the discussion of tritium
14 and the secondary issue of the ICRP-30 versus
15 60-whatever (unintelligible) and so we'll leave
16 that to -- to task one and -- and they're being
17 ignored for the time being. Is that reasonable
18 to --

19 **MR. HINNEFELD:** I think that would be
20 reasonable from our standpoint. I think if --
21 if -- if you want to mention that there is this
22 issue that's being pursued in the Savannah
23 River -- there is issue that is being pursued -
24 - I mean the issue's being pursued in Savannah
25 River, we say yeah, great, so say it, that's

1 fine by us. I think the key feature here is
2 that there is no expectation to resolve it as
3 part of their product. That would be my view.
4 That's what I would hope to come to
5 (unintelligible) looking at you guys.

6 **MR. GIBSON:** We can't speak for the Board, but

7 --

8 **MR. HINNEFELD:** But -- okay, you're right.

9 **MR. GRIFFON:** Right.

10 **MR. HINNEFELD:** You're observing us, I'd
11 forgotten, so --

12 **MR. FITZGERALD:** Well, I think -- yeah, this is
13 Joe. I think there'll be more issues like this
14 as we proceed forward where the dose
15 reconstruction reviews will overlap and catch
16 up with the site profile reviews and where we
17 can handle all the generic issues, that seems
18 to be more efficient.

19 Now certainly there's complications when the
20 site review is months and months perhaps down
21 the road and I don't know -- that would be up
22 to the Board. The Board may want
23 (unintelligible) sooner, which you know, we can
24 -- we can certainly accommodate that, as well.

25 **DR. H. BEHLING:** But the truth out of -- this

1 is Hans. The truth -- this whole issue of
2 having -- not having had a review of the site
3 profile at a time close in (unintelligible)
4 applied to other facilities, as well. So this
5 is not a unique situation. In fact, we will
6 probably address this before many of the other
7 site profiles will even be looked at. So as
8 far as I'm concerned, this is probably more
9 properly addressed in the -- under task one,
10 because it's not unique to the Savannah River
11 issue at all.

12 **MR. HINNEFELD:** Right. And in fact, we've
13 already made this decision with respect to
14 Bethlehem Steel.

15 **DR. H. BEHLING:** Yeah.

16 **MR. HINNEFELD:** We made that decision early on
17 that we would just defer those to Bethlehem
18 Steel discussion.

19 So that takes care of high five, as well? Do
20 you want to have some cursory discussion --

21 **MR. GRIFFON:** Yeah, I think we want to
22 (unintelligible) high five anyway --

23 **MR. HINNEFELD:** Okay.

24 **MR. GRIFFON:** -- the same way, you know
25 (unintelligible).

1 **MR. HINNEFELD:** Okay. This is issue number
2 eight. This is the generic -- sometime -- I
3 generally refer to it as the Savannah River
4 high five generic issue. There's the
5 description in OTIB-1, Technical Information
6 Bulletin 1, which is a -- essentially an
7 overestimate of intakes (unintelligible)
8 estimating internal exposures for Savannah
9 River for certain cases at Savannah River. The
10 approach that was taken was to capture the
11 catalog of highest intakes recorded at Savannah
12 River since they've been cataloguing these
13 exposures, and say what is -- let's presume
14 that these -- this group of people or these --
15 group of claims that we're going to take this
16 approach with, we're going to use this for
17 claims that have either bioassay data that
18 shows that they had very small, if any,
19 intakes; or people who were not monitored and
20 appropriately not monitored -- really looks
21 like they were not monitored because they
22 didn't need to be monitored. And let's say --
23 just let's -- we shouldn't necessarily say they
24 had zero internal exposures and, you know, a
25 relatively large internal exposure in these

1 cases won't -- won't carry the day. So why
2 don't we invent a hypothetical large intake,
3 assign it to this category of claims in order
4 to be able to demonstrate that we have not
5 shorted them on internal exposure just because
6 we couldn't reproduce it from the bioassay
7 record. We gave them quite a hefty internal
8 exposure and still didn't carry the day on
9 compensation (unintelligible). So that was the
10 strategy behind doing this.

11 The intakes that were selected for -- for
12 building this hypothetical intake were the
13 highest -- highest five intakes for a series of
14 radionuclides, and I don't even know how many
15 there are sitting here today, that were used at
16 Savannah River because Savannah River had
17 catalogued their intakes for quite some time.
18 They have a pretty extensive catalog of all the
19 intakes they've had there.

20 So by taking this large number, we have this
21 large hypothetical intake that, by all -- you
22 know, the evidence tells us never occurred.

23 The method that Savannah River used to identify
24 the intakes was to use the bioassay record of
25 the employee, and from that bioassay record

1 deduce what intake that person received using
2 the ICRP-30 models, which were the models that
3 were applicable at the time and in fact still
4 the models that guide the regulations in the
5 country. So the -- those models have somewhat
6 different excretion patterns associated with an
7 intake than the newer ICRP-60 models that we
8 utilize as part of this program, and therefore
9 the -- the values of those intakes was
10 questioned by SC&A reviewers since it was done
11 with the prior ICRP guidance when we use ICRP-
12 60. So the actual numerical value of the
13 intake is being questioned, is it derived
14 appropriately.

15 We've looked at this a lot and not -- you know,
16 in terms of the -- there are some complicating
17 factors here. Both the ICRP-30 and the ICRP-60
18 models have three solubility classes or
19 absorption classes. In the current version
20 they are called slow, medium and fast, so we
21 can just refer to them that way. They have
22 different designations in 30, but let's just
23 think of them as the slow, medium and fast
24 categories. And while they each have those
25 three solubility categories, they don't -- the

1 slow in ICRP-30 doesn't behave exactly like the
2 slow in ICRP-60. The medium in ICRP-30 doesn't
3 behave exactly like the medium in ICRP-60 -- or
4 whatever I said. So there -- because of that,
5 the translation of one to the other in terms of
6 the intake becomes a relatively complicated
7 problem. And we've done a fair amount of
8 analysis to try and decide how we appropriately
9 analyze what Savannah River did and arrive at a
10 good high five intake.

11 You know, on the face of it, for someone who's
12 doing dose reconstructions and not trying to
13 figure out the ins and outs of the ICRP models,
14 what we have done is provided a large
15 hypothetical intake that didn't happen and
16 providing a large dose to these people who are
17 -- for a part of this dose reconstruction that
18 in many cases we have bioassay data that
19 indicates they clearly didn't have that dose.
20 And in fact in most cases, it's absolutely not
21 credible for them to have those doses. So I
22 guess my own approach is whether it's truly the
23 average of the five largest intakes or whether
24 it turns out to be the average of the eight
25 largest intakes or some value slightly less

1 than that -- that average of the five highest
2 intakes, it's still a huge intake that these
3 people didn't get. And so the dose
4 reconstruction approach appropriately bounds
5 these people's internal dose, and so the
6 outcome of the debate is -- from a dose
7 reconstruction standpoint, is almost
8 irrelevant, I just (unintelligible).

9 So having said that, though, we are interested
10 in understanding the issue as fully as
11 possible, and so I think Hans certainly
12 understands it more than I do. I don't know if
13 you're dying to say anything or not, Hans. The
14 discussion will -- unfortunately, the
15 discussion will necessarily become quite
16 technical, I think --

17 **MR. GRIFFON:** I have a -- a -- I have a
18 hypothetical resolution that might appease
19 Joyce and -- and me, and that would be --
20 'cause my concern is one step back, that did
21 NIOSH or ORAU validate the high five --

22 **MR. HINNEFELD:** (Unintelligible)

23 **MR. GRIFFON:** -- and my impression is that you
24 got the intakes from Savannah's database
25 (unintelligible). I may be wrong about that,

1 but my impression was that you -- you took
2 their numbers of intakes -- maybe you knew a
3 little about the class or the compound and that
4 sort of thing. You didn't take their urine
5 data or whatever and recalculate intake
6 (unintelligible) --

7 **MR. HINNEFELD:** No, (unintelligible) we -- we
8 used intakes (unintelligible) by Savannah
9 River.

10 **MR. GRIFFON:** So if -- if -- if you could go
11 back that step and recalculate and just use the
12 60 models, then we'd -- everybody'd be happy.
13 Joyce would have the models right and I would
14 have my validation (unintelligible) you went
15 back to the raw data and -- because I think --
16 you know, again, okay, those intake numbers are
17 very high. What looks high in today's world
18 may not have -- you know, who knows?

19 **MR. HINNEFELD:** May not have -- yeah.

20 **MR. GRIFFON:** Yeah, so it's worth -- it's worth
21 stepping back and validating, and it gives the
22 claimant the benefit that you did that step,
23 you didn't just say -- 'cause we hear it all
24 the time that -- that the claimants say we
25 don't trust DOE's data. Well, no, we can step

1 back and look at the raw data. We recalculated
2 this ourselves and so you -- you do that
3 validation step, as well as you can recalculate
4 it using the new model (unintelligible).

5 **MS. K. BEHLING:** This is Kathy Behling, and
6 just to expand on that validation, the other
7 thing I would be curious about as to whether
8 those urinalysis were taken -- what reason they
9 were given the urinalysis. Was it a routine or
10 was it an investigation because of an incident.
11 Because if those are high routine urinalysis
12 that weren't -- and the previous one was taken
13 one year before that and we don't know when
14 that incident occurred that may have created
15 that height -- you know, this high urinalysis,
16 that becomes a significant issue.

17 **MR. HINNEFELD:** Well --

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

19 **MR. HINNEFELD:** -- we didn't take the high bio-
20 - highest bioassay data. It was -- they had
21 estimated intake from a collection of bioassay
22 data (unintelligible) --

23 **MR. GRIFFON:** I'm -- I'm -- (unintelligible).

24 **MR. HINNEFELD:** -- (unintelligible) intake
25 value.

1 **MS. K. BEHLING:** Is that right?

2 **MR. HINNEFELD:** There was an intake value that
3 (unintelligible) --

4 **MR. GRIFFON:** And I'm (unintelligible) --

5 **MR. HINNEFELD:** -- based on the
6 (unintelligible) bioassay data.

7 **DR. H. BEHLING:** Stu and I already discussed
8 this because the critical issue is that if you
9 start out with the five highest urine values,
10 you may not have the highest doses because if
11 the dose was -- or if the exposure was received
12 the day before as the result of a radiological
13 incident, the urine data will clearly be high.
14 But if it's a routine and you don't know when
15 the intake was, even a modest presence of
16 plutonium in urine, but if it was taken 180
17 days prior to this or whatever, would have a
18 much higher intake, even though the urine level
19 was lower than a high urine concentration that
20 follows a radiologic incident that was assessed
21 the day after.

22 **MR. HINNEFELD:** Right.

23 **DR. H. BEHLING:** So we have to be careful what
24 does the high five represent.

25 **MR. HINNEFELD:** And it is the intakes, the high

1 five (unintelligible).

2 **DR. H. BEHLING:** And it should be intake. But
3 now the question is what were the assumptions
4 for the intake?

5 **MR. GRIFFON:** Right, (unintelligible) --

6 **DR. H. BEHLING:** How can you not
7 (unintelligible) --

8 **MR. GRIFFON:** -- I know that may, I believe,
9 (unintelligible) all those they probably have
10 case write-ups on how they did those --

11 **MR. HINNEFELD:** Yeah, I (unintelligible).

12 **MR. GRIFFON:** Yeah.

13 **MR. HINNEFELD:** Now when you were talking about
14 validation of the original data, how raw -- up-
15 to-date are you looking for? I mean are you
16 looking -- I mean there would be bioassay
17 results in this first (unintelligible), but
18 they would -- Savannah River probably has
19 already provided or certainly we can get the
20 actual bioassay results (unintelligible). Is
21 that what you're thinking?

22 **MR. GRIFFON:** Yeah, I -- I guess that's open
23 for discussion, you know, (unintelligible) --

24 **MR. HINNEFELD:** And it's not really for this
25 group.

1 **MR. GRIFFON:** Right -- yeah, for the whole --
2 whole -- you know, but I -- I think at least
3 starting off with their case write-ups and
4 using their raw (unintelligible) raw data
5 there, maybe not going back to laboratory log
6 books and that (unintelligible).

7 **MR. HINNEFELD:** Right.

8 **MR. GRIFFON:** That would be a -- that may be
9 hard to find.

10 **MR. HINNEFELD:** Okay.

11 **MR. GRIFFON:** Then that -- then that alleviates
12 that -- that sort of guesswork of okay, I've
13 got these intake numbers. How can -- how can --
14 -- what kind of corrections do I have to do to
15 get (unintelligible) ICRP-60 -- you know --

16 **MR. HINNEFELD:** Right.

17 **MR. GRIFFON:** -- you plug in to that number,
18 you may be quicker to go back and recalculate.

19 **MR. HINNEFELD:** Yeah.

20 **MR. TOMES:** This is Tom Tomes. I have, just in
21 the course of reviewing claims, ran across and
22 matched up an intake that (unintelligible) high
23 five (unintelligible) I just coincidentally ran
24 across one with the claimant. I didn't
25 evaluate him but -- but as far as evaluation of

1 the intake that we assigned, there was an
2 evaluation done and quite complicated in terms
3 of -- to -- to determine what the effect of --
4 of (unintelligible) models, you know, between
5 the two -- ICRP-30 and ICRP (unintelligible)
6 models and that was evaluated and determined to
7 be that the -- that the -- for most of these
8 (unintelligible) it would be a -- would be a
9 lower intake, which (unintelligible) --

10 **MR. GRIFFON:** Yeah, I don't (unintelligible) --

11 **MR. TOMES:** -- that -- that -- that would be
12 more -- not conservative or not -- be more --
13 be more favorable by (unintelligible) exact
14 evaluation, that's just -- but the numbers are
15 in the TIB that actually show various
16 (unintelligible) what your ratio of -- of a
17 dose to be -- or intake to be.

18 **MR. GRIFFON:** And -- and you know, I -- I guess
19 my issue's a little bit separate because
20 regardless of the outcome, I think that that
21 (unintelligible) of going back and validating
22 that (unintelligible) that they were, you know
23 -- I mean you may look at the write-up and --
24 and say oh, I don't agree with their approach.
25 You may get a higher intake even though you use

1 -- particular model, you know, (unintelligible)
2 independently to check those intakes is a
3 (unintelligible) --

4 **THE COURT REPORTER:** I can't hear you.

5 **MR. GRIFFON:** -- model or the wrong model.

6 **MR. HINNEFELD:** Okay. So can we conclude with
7 our decision that this will be addressed more
8 fully in the Savannah River profile review?

9 **MR. TOMES:** Yeah, I -- and in fact it is being
10 addressed so I would just urge that we
11 (unintelligible) there.

12 **MR. HINNEFELD:** Okay.

13 **MR. TOMES:** Same thing for the next one, the
14 question of how incidences are addressed
15 (unintelligible) site profile is looking at --
16 these generic issues are being addressed in the
17 --

18 **MR. HINNEFELD:** Okay. Now as I understand
19 this, these incidents described here were
20 actually in the DOE response that -- these were
21 things that were in the record for this person,
22 a tritium exposure incident and a relatively
23 high tritium bioassay sample.

24 **MR. TOMES:** Okay, you're right, this is sort of
25 a dual issue. This is appropriate for this in

1 terms of the representation (unintelligible)
2 the generic issue.

3 **MR. HINNEFELD:** So there was a -- you know,
4 there were some incident report type
5 information provided on this case.

6 **MR. TOMES:** Right. This is individual as well
7 as a generic question.

8 **MR. HINNEFELD:** Okay. Anybody want any
9 additional discussion on number nine? We
10 started talking about nine a little bit on the
11 (unintelligible) issue. We -- there are a
12 number of -- like I said -- incident type
13 information provided by the DOE with the expos-
14 - with the response on this, and we have a
15 little -- we provide a particular description
16 of how, in the dose reconstruction, has
17 bracketed the doses (unintelligible) dose
18 incident.

19 **DR. H. BEHLING:** Stuart, just for the audience
20 here, let me give you the next slide here,
21 which is 12.3, and -- and you see, for those
22 who are close enough, the bullets that were
23 identified as issues here. And at the bottom -
24 - and I'll just read it. At the very bottom I
25 state that SC&A has not evaluated the

1 significance of these data and it is uncertain
2 whether radiological incident records of this
3 claim-- for this claimant are complete. As a
4 result, SC&A is uncertain whether NIOSH's
5 stated assumptions and decisions are correct,
6 scientifically valid or claimant favorable.
7 Well, in light of the assignment of
8 hypothetical doses against those, I did do a
9 back-of-the-envelope calculation and in each
10 case concurred that the -- the hypothetical
11 intakes exceed what might have been the
12 potential exposure as a result of these
13 incidents, with the exception of the high five
14 issue that is a separate issue.

15 **MR. HINNEFELD:** The one that's (unintelligible)

16 --

17 **DR. H. BEHLING:** As far as I'm concerned -- you
18 know, at the time when I -- when I had to write
19 this, I didn't have the luxury of going back
20 and analyzing what was assigned in regard to
21 accommodating these radiologic incidents, but I
22 have since then looked at them -- looked at
23 these, sort of did a back-of-the-envelope
24 calculation and concluded that your bases are
25 covered by hypothetically (unintelligible).

1 MR. HINNEFELD: Okay.

2 **MR. GRIFFON:** I guess for me the other
3 exception is the eight -- eight lost or -- or
4 damaged badges. (Unintelligible) I look back
5 at 37 percent. I know with the high five you
6 give them a lot of benefit of the doubt, but is
7 that close enough to chase those down a little
8 more? I don't know, I --

9 MR. HINNEFELD: Well, I think we can certainly
10 pull up to what they say --

11 MR. GRIFFON: Right, right (unintelligible)
12 check on that.

13 **MR. GIBSON:** (Unintelligible) high five get to
14 sit in a truck and drink beer on company pay
15 for weeks at a time like they did at Mound?

16 **MR. HINNEFELD:** Oh, I don't know. I don't
17 know.

18 (Pause)

19 **MR. HINNEFELD:** Okay, are we ready for 13 --

20 MS. MUNN: Yes.

21 **MR. HINNEFELD:** -- case #13? All right.

22 PRESENTATION/DISCUSSION OF ISSUES FOR CASE #13

23 DR. H. BEHLING: Okay. Case #13 is our last of
24 the Savannah River Site claims. The individual
25 here was only employed very briefly between --

1 well, I won't mention even the -- the month.

2 It was in , but the time frame

3 covers less than The person was

4 engaged in at a site in the

5 . He

6 developed prostate cancer in and based on

7 the assigned dose of 3.96 rem he received a

8 probability of causation value of 3.19 percent,

9 so low, non-compensable claim.

10 **MR. HINNEFELD:** The first issue -- or the first
11 two issues are the generic issues we just
12 discussed, Savannah River high five and the
13 organically-bound tritium issue.

14 And then the third, and the only one that --

15 which we wanted to comment on was the comment

16 by the dose reconstructor that the items or

17 comments made in the interview -- claimant

18 interview were not addressed. And I think this

19 probably fits in the category that we talked

20 about earlier, that the claimant is entitled to

21 understand that the information they provided

22 is -- has been evaluated and utilized in the

23 dose reconstruction. We have prepared a little

24 response. The specific items involved were two

25 very short duration incidents. This case was

1 given the Savannah River high five hypothetical
2 intake, so the dose reconstruction's solid --
3 is a solid case, but we agree that the
4 claimants are entitled to a description of how
5 the information provided (unintelligible).

6 **DR. H. BEHLING:** There's no comment. I had, in
7 my write-up, said that based on the nature of
8 the radiologic incidents and the worker's claim
9 that no investigation or bioassays were
10 performed for either incident, the potential
11 exists for internal exposures which were not
12 accounted for specifically. However, SC&A also
13 does acknowledge that the NIOSH-assigned
14 hypothetical internal doses for tritium and
15 other nuclides are likely to be significantly
16 greater than those that may have resulted from
17 these incidents. So we didn't consider the
18 issue, we just stated that the -- the
19 radiological incidents, in themselves, were not
20 necessary (unintelligible), but given the
21 hypothetical intake and the doses assigned, the
22 likelihood is that he was assigned a much
23 larger dose than would have been the case had
24 these incidents been investigated.
25 So that's it for --

1 **MR. HINNEFELD:** Completes our plan for the day.
2 Right?

3 **MR. GRIFFON:** Yeah.

4 **DR. H. BEHLING:** So we can start tomorrow with
5 case #16, and are we in agreement that we will
6 start as early as 8:30? I haven't heard
7 affirmative from -- from Wanda.

8 **MS. MUNN:** You've only heard moans from Wanda.

9 **DR. H. BEHLING:** If we hear any snoring, Wanda,
10 we'll wake you up.

11 **MS. MUNN:** 8:30 is fine.

12 **DR. H. BEHLING:** Okay. So we'll close for the
13 night and we'll try again, and hopefully
14 tomorrow's telephone connections won't have as
15 many problems as we did today.

16 **MS. K. BEHLING:** And use these telephone
17 numbers to call in tomorrow again.

18 **MS. MUNN:** All right.

19 **DR. H. BEHLING:** Okay. Well, have a good night
20 and we'll talk to you in the morning.

21 **MS. MUNN:** Thank you.

22 (Whereupon, the teleconference adjourned at
23 5:15 p.m.)
24
25