

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

convenes the

SEVENTEENTH MEETING

ADVISORY BOARD ON
RADIATION AND WORKER HEALTH

VOLUME II

The verbatim transcript of the Meeting of the
Advisory Board on Radiation and Worker Health held
at The Westin Cincinnati, 21 East Fifth Street,
Cincinnati, Ohio, on August 19, 2003.

NANCY LEE & ASSOCIATES
Certified Verbatim Reporters
P. O. Box 451196
Atlanta, Georgia 31145-9196
(404) 315-8305

C O N T E N T S

August 19, 2003

REGISTRATION AND WELCOME
 Dr. Paul Ziemer, Chair. 7
 Mr. Larry Elliott, Executive Secretary

ORAU CONTRACT SUPPORT STATUS
 Dr. Richard Toohy, ORAU. 8

PRESENTATION
 Dr. John Till, RAC. 48

STATUS OF TECHNICAL BASIS DOCUMENT/SITE PROFILE DEVELOPMENT
 Dr. Jim Neton, NIOSH. 108

ADMINISTRATIVE HOUSEKEEPING AND BOARD WORK SCHEDULE
 Dr. Ziemer, Mr. Elliott, Ms. Homer. 159,248

BOARD DISCUSSION/WORKING SESSION DEVELOPMENT OF TASK ORDER
 Mr. Mark Griffon. 164

PUBLIC COMMENT PERIOD. 262

ADJOURN. 284

COURT REPORTER'S CERTIFICATION. 285

TRANSCRIPT LEGEND

The following transcript contains quoted material. Such material is reproduced as read or spoken.

In the following transcript a dash (--) indicates an unintentional or purposeful interruption of a sentence. An ellipsis (. . .) indicates halting speech or an unfinished sentence in dialogue or omission(s) of word(s) when reading written material.

In the following transcript (sic) denotes an incorrect usage or pronunciation of a word which is transcribed in its original form as reported.

In the following transcript (phonetically) indicates a phonetic spelling of the word if no confirmation of the correct spelling is available.

In the following transcript "uh-huh" represents an affirmative response, and "uh-uh" represents a negative response.

In the following transcript "*" denotes a spelling based on phonetics, without reference available.

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

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

(By Group, in Alphabetical Order)

BOARD MEMBERS

CHAIR

ZIEMER, Paul L., Ph.D.
Professor Emeritus
School of Health Sciences
Purdue University
Lafayette, Indiana

EXECUTIVE SECRETARY

ELLIOTT, Larry J.
Director, Office of Compensation Analysis and Support
National Institute for Occupational Safety and Health
Centers for Disease Control and Prevention
Cincinnati, Ohio

MEMBERSHIP

ANDERSON, Henry A., M.D.
Chief Medical Officer
Occupational and Environmental Health
Wisconsin Division of Public Health
Madison, Wisconsin

ANDRADE, Antonio, Ph.D.
Group Leader
Radiation Protection Services Group
Los Alamos National Laboratory
Los Alamos, New Mexico

DeHART, Roy Lynch, M.D., M.P.H.
Director
The Vanderbilt Center for Occupational and Environmental
Medicine
Professor of Medicine
Nashville, Tennessee

ESPINOSA, Richard Lee
Sheet Metal Workers Union Local #49
Johnson Controls
Los Alamos National Laboratory
Española, New Mexico

GIBSON, Michael H.
President
Paper, Allied-Industrial, Chemical, and Energy Union
Local 5-4200
Miamisburg, Ohio

GRIFFON, Mark A.
President
Creative Pollution Solutions, Inc.
Salem, New Hampshire

MELIUS, James Malcom, M.D., Ph.D.
Director
New York State Laborers' Health and Safety Trust Fund
Albany, New York

MUNN, Wanda I.
Senior Nuclear Engineer (Retired)
Richland, Washington

PRESLEY, Robert W.
Special Projects Engineer
BWXT Y12 National Security Complex
Clinton, Tennessee

ROESSLER, Genevieve S., Ph.D.
Professor Emeritus
University of Florida
Elysian, Minnesota

AGENDA SPEAKERS

Dr. John Till, RAC

Dr. Jim Neton, NIOSH

Dr. Richard Toohy, ORAU

Mr. Mark Griffon, Workgroup Leader

STAFF/VENDORS

CORI HOMER, Committee Management Specialist, NIOSH
STEVEN RAY GREEN, Certified Merit Court Reporter

AUDIENCE PARTICIPANTS

STEVEN AHRENHOLZ
JOHN ALEXANDER
EULA BINGHAM
DENISE BROCK
HELEN BUELIN
JULIA DEHART
JOHN DEMENT
LOU DOLL
JAMES EAST
RUSS HENSHAW
LIZ HOMOKI-TITUS
R. DELON HULL
JUDSON KENOYER
DAVID KOCHER
JEFF KOTSCH
MICHELE R. LANDIS
JAY MAISLER
PAULA MCCREARY
RICHARD MILLER
JOHN S. MORAWETZ
DAVID NAIMON
STEVE POWELL
LOUISE S. PRESLEY
HARRY RICHARDSON
D.M. SCHAEFFER
MARY SCHUBAUER-BERIGEN
BOB TABOR
RICHARD TOOHEY
BRANT ULSH
DAVID UTTERBACK

1 report and then we'll be back onto the
2 presentation by Dr. Till.

3 So let's begin then with Dr. Richard Toohey
4 from ORAU.

5 **ORAU CONTRACT SUPPORT STATUS**

6 **DR. TOOHEY:** Okay, are we on? Can you hear
7 me? Better? Okay, great. Thank you.

8 All right. Good morning. I'll go through my
9 presentation and try to answer all the questions
10 you asked Dave Sundin yesterday. As you know,
11 we're just about coming up on one year of the
12 ORAU team contract with NIOSH for dose
13 reconstruction support. And to refresh your
14 memory, our contract -- or our effort, I should
15 say, is organized into six different tasks.

16 Task one is database management, the computer
17 operations.

18 Task two is data collection for claims and
19 petitions. That's all been related to claims so
20 far. They receive the DOE submittals of
21 individual monitoring data, scan that in. Any
22 data that is captured to field trips to records
23 repositories and that, that group also scans in.
24 We also have a number of health physicists in
25 that group who review claimant files, make a

1 determination if they are in fact ready for dose
2 reconstruction, looking for things like gaps in
3 monitoring data. We also have some QA people
4 review files looking at the Department of Labor-
5 supplied information to see if there are any
6 problems with that data that might hold things
7 up.

8 Task three is dose reconstruction research.
9 That's headed by Judson Kenoyer with Dade Moeller
10 & Associates. Judson's here today. And their
11 primary effort right now is developing the
12 technical basis documents or the site profiles,
13 whatever you want to call them. And I'll talk a
14 little more about that effort, but the primary
15 presentation on that will be by Dr. Neton later
16 this morning.

17 We made a little change recently. You may
18 recall task four last time I showed this slide
19 was simply called CATI, Computer-Assisted
20 Telephone Interviews, with the claimants. We
21 have moved some other operations into that same
22 task and we now call it Claimant Contact. And
23 the things we moved in there were the dose
24 reconstruction assignment letters, the close-out
25 interviews with the claimant. Also mailing out

1 the dose reconstructions and the OCAS-1 forms
2 which we're taking over from NIOSH and things
3 like that, and the 800 number operation we've
4 also moved into that task. So we've just
5 consolidated all the claimant contact into one
6 group. We have neither added nor deleted
7 anything we were doing. We just took those last
8 things I mentioned out of task five, dose
9 reconstruction; put them where they made more
10 sense and also we're having them done by people
11 who have better people skills than your average
12 health physicist.

13 Task five of course is the main operation,
14 the dose reconstruction generation itself.

15 And then task six, the technical and program
16 management support.

17 So how many folks have we got working on this
18 thing now? We've got -- these are full-time
19 equivalents. There's actually more people than
20 that. We have a number of part time people,
21 especially in task two, doing the claim review.
22 Some are ORAU employees in our Colorado office,
23 and some are working on the beryllium project and
24 they had some time available and so we adopted
25 them, working on that. So we've got 29 FTEs on

1 task two.

2 The big one is 102 on task three. And again,
3 Dr. Neton'll talk about that. We front-end
4 loaded this because we made the decision
5 generating these technical basis documents is
6 really the first thing we need to do, and the
7 light finally went on that it was going to take
8 us an awful long time to do this with our own
9 resources. So we decided to subcontract a lot of
10 it out, and we have now assembled I think 13 TBD,
11 technical basis document, teams, most of which
12 are subcontractor operations. And again, Dr.
13 Neton will show you that in detail, but it's
14 basically -- we've taken these subcontractors,
15 some of whom we had worked with before, some of
16 whom had been partnered with the SAIC Battelle
17 proposal -- I mean there aren't that many health
18 physics companies out there. But just giving a
19 given company the task to produce the technical
20 basis document for a given site.

21 Of course we have our own people overseeing
22 the task and working with them. We've also
23 involved OCAS staff early on in this process to
24 help expedite the eventual review process. If
25 we're heading down the wrong road early on, then

1 there's no sense wasting a lot of time and effort
2 and not finding that out until it goes in for
3 final review.

4 And if a contractor -- or subcontractor, I
5 should say, does a good job on a document,
6 they'll get another one. If they don't, well,
7 thank you for your services and don't call us,
8 we'll call you. So we think it's an efficient
9 way to get this done, front-end load, and I would
10 expect a year from now that number of 102 will be
11 probably down to around 30 or so.

12 Task four on the -- well, this still shows
13 CATI, but it's all the claimant contact, is now
14 21 FTEs.

15 The majority of people in the health
16 physicists are the 98 folks actually doing dose
17 reconstruction. And then 18 on management
18 support, so it's a total of 285 FTEs, but it's
19 about 320 warm bodies or so when you could the
20 part-timers.

21 Okay. The facilities and equipment. We've
22 set up our Cincinnati Operations Center out in
23 Norwood, was five minutes away from the NIOSH
24 location until they moved last month, but now
25 it's only about 15 minutes away. We've got -- I

1 went metric on this -- 1,400 square meters. And
2 we also set up a separate telephone interview
3 facility that's about a block away from that.
4 Some of you did visit our facility some months
5 ago for the training effort for some of you, I
6 think the working group for the Board oversight
7 contractor has seen that.

8 We've got a computer network set up --
9 actually it's more than 300 users now, but they
10 are spread all over the country. And of course
11 the big thing we've had on that is security
12 protection, so we've been very careful with anti-
13 viral software and firewalls and all that sort of
14 thing. And I am pleased to report to you that so
15 far we have not had any viruses or worms getting
16 into our system.

17 And we've also established telecommunications
18 and data transfer. We have a high-speed link to
19 NIOSH for data transfer back and forth. And we
20 also have a link to the Dade Moeller office in
21 Richland. They're doing a lot of the up front
22 data entry, inputting say monitoring records for
23 an individual worker into a spreadsheet from
24 whence they can then be copied and plugged into
25 the IREP spreadsheet, and it just expedites the

1 actual physical production of the dose
2 reconstruction report. We're increasing the band
3 width on that, the -- we were thinking of putting
4 in a dedicated T-1 line out there but we found
5 out Dade Moeller & Associates, their internet
6 service provider can give them up to a megabyte
7 band width, so they're just going to expand that,
8 so that'll come in pretty quickly.

9 All right. Now, the thing everybody's
10 interested in, the performance plan or the
11 production plan. As you heard yesterday from
12 Pete Turcic, we were -- we were originally hoping
13 to do about 6,000 this year. And generally
14 that's not going to happen. Our current best
15 estimate, what we really think we can produce, is
16 about 4,000.

17 As of last week we have completed and turned
18 in to NIOSH -- let me make sure I have the right
19 number here -- 850 dose reconstruction reports.
20 Many of -- the vast majority of those have been
21 from Bethlehem Steel and Savannah River, but not
22 exclusively, and I'll talk a little bit more
23 about how we're doing those. We've been
24 averaging 75 a week for about the last month.
25 We're ramping that up to -- oh, 100 to 125 a

1 week. Next month, in September, we plan to be
2 doing 150 and in October get to about 200 a week
3 and just hold it there.

4 Now, the question came up yesterday about
5 clearing the backlog and how long that's going to
6 take. And the answer to that depends on your
7 definition of clearing the backlog. The first
8 definition is working through the 13,000 or so
9 claims that are already in the hopper. And at a
10 production rate of about 200 a week, we will
11 estimate we will be through those in November,
12 2004.

13 The operational definition of clearing the
14 backlog, which Larry Elliott and his staff have
15 put as a goal, is to have no claims in the hopper
16 that are over one year old. So I had to apply a
17 little calculus to work this out, and on the
18 assumption that we do 200 a week, but 100 new
19 ones come in a week, we get to the no claims over
20 one year old in April of 2005. At that point
21 we'll work through and then in the fall of 2005
22 we think the average age of a claim will be about
23 90 days. And we estimated if input continues,
24 new claims coming in at about 100 a week, we will
25 always have about a 90-day supply on hand, or

1 about 1,200 to 1,500 claims in the hopper.

2 So our -- we should have actually a little
3 bit over 4,000 done this year. Right now we're
4 about a week behind. We got into a little more
5 detailed discussion with NIOSH on a revision to
6 the Savannah River document that was looking at
7 some aspects of internal dosimetry, but we got
8 their comment back last week. Our replies to the
9 comments are going back to NIOSH tomorrow. We
10 don't see any show-stoppers there, so we fully
11 expect to be able to process the rest of the
12 Savannah River claims.

13 Let me go on and discuss the sites we're
14 heading. As Dave -- or the sites we're aiming
15 at. As Dave Sundin mentioned yesterday, we've
16 decided to approach this in what we think is a
17 way that would do the most good for the most
18 number of people in the least amount of time, and
19 that is essentially batch processing. And once a
20 -- the site profile has been completed, the
21 technical basis document has been done, we're
22 just going to try to do all the claims -- or as
23 many as can be done -- from that site. And the
24 order in which we decided to attack the sites was
25 simply on the order of how many claims are from

1 the site. Savannah River and Y-12 normally run
2 neck and neck. One month Savannah River will
3 have more, the next month Y-12 will have more.
4 But in point of fact, there -- only about half of
5 the claims that show Y-12 as a work site, the
6 workers worked only at Y-12. About half of them
7 also worked at X-10 or K-25, and especially for
8 the trades because they would cover all three
9 sites. Many people who were assigned and had
10 offices at X-10, for example, actually had their
11 labs at Y-12 and so on and so forth. So we are
12 going ahead with Y-12 as an early on. But you'll
13 notice Oak Ridge National Lab and the Oak Ridge
14 gaseous diffusion plant are right there and we
15 hope to get all three of those done at the same
16 time.

17 The next major site we plan to have the
18 document done for is Hanford. The external
19 dosimetry and X-ray portions of that document
20 have been completed and we expect the rest of it
21 to be done and in for NIOSH review by the end of
22 this month.

23 We're also working on the Iowa ordinance
24 plant or the Iowa Army ammunition plant,
25 depending on which reference you look at. It's

1 scheduled to be done by the end of this month.
2 That may slip a week or two, but in point of
3 fact, we really can't process those claims until
4 the dosimetry data has been made available from
5 Defense Department. And we, together with NIOSH,
6 are actively pursuing capturing those records.

7 So then later on this fall, we will be
8 finishing up Rocky Flats and Los Alamos. Also
9 will get the technical basis documents done this
10 year for Idaho and a few other sites, but we
11 won't actually be processing claims this year.

12 I think Jim Neton may have mentioned
13 yesterday, once we've got the site profile done
14 and approved and everybody's happy with it,
15 there's about a one-month lag time before we can
16 actually start doing claims from that site. A
17 couple of things come into play there. One is
18 the dose reconstructor assignment letter, and we
19 give the claimant two weeks to offer any
20 objection they may have to the assigned dose
21 reconstructor. So far, out of over 1,200
22 assignments, we've only had two claimants raise
23 an issue about that.

24 The second thing of course is the telephone
25 interview, and that needs to be scheduled, and

1 then also the claimant gets two weeks to turn
2 around the draft telephone interview report that
3 gets sent out. So there's some built-in lag time
4 in there.

5 The second thing is it also takes us about a
6 month to put some of the data in the site profile
7 into spreadsheets which then serve as templates
8 for the dose reconstruction. And we do go over
9 those spreadsheets with NIOSH and there's a
10 verification and validation procedure to make
11 sure the thing -- they are actually doing the
12 dose calculation that we think they are doing.
13 But then that's an efficiency measure. With the
14 monitoring data entered up front and the
15 spreadsheet, the dose reconstructor has to put in
16 some of the personal specific information. Much
17 of it gets downloaded automatically from NIOSH's
18 NOCTS database. And there's relatively few
19 things in terms of data entry the health
20 physicist has to do. About the only thing they
21 still have to do by hand is enter some of the
22 bioassay data into the IMBA program to do the
23 internal dose calculation. So we've attempted to
24 streamline that as much as possible, but it does
25 take about a month to generate those spreadsheets

1 and get them debugged and distributed, make sure
2 they're working.

3 On the AWE sites, of course Bethlehem Steel
4 was the first one we've gotten in, and we're
5 currently developing what we'll call Bethlehem
6 Steel clones, other rolling mills that also
7 rolled those billets down. Let's see, that's
8 Bridgeport Brass -- I'm drawing a blank on the
9 other ones, there's two or three -- Simonds Saw
10 and Steel, thank you. That's one of the other
11 ones.

12 The Blockson Chemical document was in. We're
13 on our second round of comments and review on
14 that. There's only -- there was one sticking
15 point on that, which we've resolved with NIOSH on
16 mutual agreement, which was dose rate from a
17 barrel of yellow cake. And we've actually found
18 some survey -- barrel survey data from Fernald on
19 uranium tetrafluoride, which is probably a little
20 bit higher than you get from yellow cake, but it
21 would certainly be claimant favorable to use
22 that. And then there are the Blockson clones,
23 the other phosphate processing plants that will
24 follow from that.

25 The Huntington Pilot plant, that one -- they

1 recovered -- was primarily to recover nickel and
2 -- that had been contaminated with uranium.
3 We've got a draft of that in for NIOSH review.
4 The one sticking point on that we're still trying
5 to figure out is what was the efficiency of the
6 nickel recovery process, because what that tells
7 us is how much uranium by mass was left in the
8 slag or the by-product. If it was very high
9 efficiency recovery, then the by-product could be
10 fairly high uranium concentration. On the other
11 hand, if it was a low efficiency, then there
12 probably won't be much difference in that. So
13 that's something we have to try to chase down.

14 And also, as you heard yesterday, we have a
15 draft document on the Mallinckrodt Chemical Works
16 which is currently undergoing internal review by
17 the ORAU team and we hope to get that to NIOSH
18 for their review in another week or two. So
19 that's basically the plan on these things.

20 I should also mention that once we've got the
21 site profile done and approved, we do try to
22 process claims from the site roughly in the order
23 in which they were received. But the total
24 processing time for a given site's probably only
25 going to cover a few months, so that's not going

1 to be a very big deal.

2 Let me also mention that we have what we call
3 supplemental dose reconstruction teams. We have
4 one assembled so far, which consists of four
5 senior health physicists, two external
6 dosimetrists and two internal dosimetrists. And
7 their assignment is start a claim, one, and start
8 going through and just work them through so that
9 people who have been in the queue for a long time
10 aren't totally neglected, waiting until we
11 finally get around to finishing their site
12 profile, so they're doing a number of items.

13 There are also some claims from other sites
14 we are doing under some efficiency protocols, and
15 let me talk about those next.

16 The first one is for potentially compensable
17 cases. And this would be workers at the
18 primarily Department of Energy facilities whose
19 records show positive bioassay results for
20 inhalation exposure to actinides or the
21 transuranics. So it would be uranium, plutonium,
22 americium, neptunium, curium, etcetrium*. Okay?
23 And they have either lung cancer or a cancer of
24 what we call a metabolic organ -- of course all
25 organs are metabolic, but in this context, it

1 means an organ which does tend to concentrate or
2 serve as a reservoir for that radionuclide. So
3 for uranium it would be kidney, primarily. For
4 the transuranics it's skeleton and liver.

5 So we will take their bioassay data, just do
6 an internal dose assessment using the IMBA
7 program, and if the probability of causation from
8 that is -- should be equal to or greater than 50
9 percent at the 99 percent confidence interval,
10 the case is likely compensable and we're finished
11 with the dose reconstruction. We're currently
12 processing Y-12 cases and there are probably
13 about 100 of those to date, and we've also done
14 some from Hanford, Rocky, Idaho and some of the
15 other sites. So that's going on and continuing.

16 So -- in fact, here's one example of that
17 protocol. Case was a Hanford engineer diagnosed
18 with lung cancer. His bioassay record had ten
19 positive plutonium urinalysis results in it -- by
20 positive we mean exceeding the MDA. The records
21 and an incident report showed a confirmed intake
22 of plutonium nitrate, so we took the bioassay
23 data, just ran IMBA. Took it back to that date
24 of the incident that was in the records and the
25 intake that came out from IMBA was 520

1 nanocuries, which is actually an awful lot of
2 plutonium. But the lung dose equivalent
3 calculated from that, from the time of intake to
4 the date of diagnosis, was a total of 88 rem,
5 which produced a probability of causation of 66
6 percent at the 99 percent confidence interval.
7 Case is finished.

8 The other efficiency protocols we're
9 developing are at the other end of the spectrum,
10 and that is a claim that is probably or
11 potentially non-compensable. So the criteria for
12 those cases are low exposure potential, a job
13 that in general did not involve hands-on work
14 with unencapsulated* radionuclides or working in
15 radiation areas, like a reactor operator you
16 would not do this way.

17 The exposure records show either zero or
18 fairly small internal and external doses, and the
19 cancer occurs in what we call a non-metabolic
20 organ, meaning an organ that does not concentrate
21 the radionuclides to which the claimant was
22 exposed. And prostate is our classic example of
23 that, but it's not the only one.

24 So we tried this at Savannah River and for
25 the internal dose side of it we looked through

1 their records and incident reports and everything
2 on the site, and we dug out what were the maximum
3 intakes ever reported for all the workers at the
4 site of specific radionuclides. And we took the
5 top five of those and averaged them. Some of
6 them there were not five intakes, so we just used
7 what we had, and we assign that intake to the
8 first day of employment. Okay? Then for tritium
9 we assigned the maximum missed dose they could
10 get, we assigned the maximum missed external
11 dose, which is -- and the number of monitoring
12 intervals times the limit of detection, LOD, of
13 the badge. We also assigned the maximum medical
14 X-ray and environmental doses. So this is in
15 fact a maximum dose estimate.

16 So for Savannah River we wrote this up in
17 ORAU technical information bulletin number one,
18 and I think that is posted and on the OCAS web
19 page, was approved last month, and there's just a
20 laundry list of radionuclides that are included
21 in this.

22 For particle size and clearance type or
23 solubility, we made the claimant-favorable
24 assumptions, picking the ones that would produce
25 the maximum dose to those organs. And the other

1 thing that to qualify for this procedure, if the
2 case was in fact monitored for internal exposure,
3 all the bioassay results must be below the
4 predicted bioassay results from this maximum
5 intake. So just assigning those -- all these
6 intakes to day one, we can calculate from IMBA
7 what should be in urine or whole body counting as
8 a function of time since exposure, and that's all
9 generated in the spreadsheet for one to 10,000
10 days post-exposure. And then what the dose
11 reconstructor has to do is look at the actual
12 monitoring data and make sure it always falls
13 below that as a function of time post-intake. Or
14 that the predicted results always exceeds the
15 MDA, minimum detectable activity, of the bioassay
16 method.

17 So as an example of that one for a Savannah
18 River claim was a claimant with male breast
19 cancer. The monitored external dose was a tenth
20 of a rem deep and .45 shallow. The missed dose,
21 which was the number of monitoring intervals
22 times the limit of detection, was .29 rem. The
23 maximum ambient environmental dose could have
24 gotten on the site was 2.2 rem. The maximum X-
25 ray dose from the annual X-rays was a tenth of a

1 rem. The maximum internal doses, the maximum
2 missed dose from tritium was about a half a rem,
3 and the maximum dose from the assigned maximum
4 potential intake was .82. So adding all those
5 up, the -- was about four and a half rem,
6 producing a probability of causation of only
7 eight percent at the 99 percent confidence
8 interval. So we deemed this case to be complete
9 at this point and -- having assigned a maximum
10 dose and still it's very far from being
11 compensable. As an efficiency procedure, we
12 would stop dose reconstruction at that point.

13 So the next thing to do is extend this
14 efficiency procedure complex-wide and developing
15 a maximum intake scenario complex-wide. And I've
16 been doing some literature searches on that,
17 reviewing the REACTS -- Radiation Emergency
18 Assistance Center Training Site -- records for
19 accidents. Also the DTPA registry for
20 transuranic intakes who were treated with DTPA, a
21 chelating agent that removes those from the body,
22 and other data sources to come up with maximum
23 intakes for these.

24 For the external dose, for most sites and
25 most dosimeters, most doses are going to be very

1 comparable to those for Savannah River 'cause all
2 the major DOE sites used very similar types of
3 dosimeters, so we're currently working on this.
4 And of course we'll submit it to NIOSH for review
5 and approval. And then that opens up a lot of
6 cases or claims that can be processed, even
7 without the full technical basis document being
8 completed for that site.

9 We also want to extend this to the Atomic
10 Weapon Employer sites where it's primarily
11 uranium exposure. And what we decided to do
12 there is assign a maximum intake at the beginning
13 of exposure that would be high enough to cause
14 acute kidney failure from chemical toxicity of
15 uranium. And under the -- if you look in the old
16 Good Practice Guide for uranium facilities, it's
17 listed as about 300 milligrams of soluble
18 uranium. But that was based on the ICRP-30 long
19 model and the older biokinetic models. If you
20 use the new lung model, the ICRP-66 version and
21 the ICRP publication 78 metabolic models, it
22 actually comes out to be about 2,000 milligram or
23 a 2-gram intake of soluble uranium.

24 And just as an example, the resulting dose
25 from that for 50 years to the prostate gland is

1 only one and a half rem.

2 So the external dose for a uranium facility
3 would be, depending on what the facility did,
4 either direct contact with a uranium slab, which
5 is about -- well, roughly 250 millirem an hour
6 shallow dose and about 10 millirem an hour deep
7 dose, or from uranium-containing barrels, and for
8 full-time exposure.

9 Now actually when I put this slide together,
10 I said whichever's higher. That's not correct.
11 I should say whichever is appropriate, depending
12 on what the site did. So for the rolling mills
13 who were working with uranium billets, it would
14 be from the contact dose with a uranium billet or
15 slab. For places like Blockson that were
16 actually processing uranium ores or things, it
17 would be from the barrel of uranium-containing
18 material.

19 One thing we said we can't do this for is for
20 skin cancers. Not that they're metabolic, but
21 there's always a potential for a higher shallow
22 dose from uranium that has gone through a melting
23 process 'cause that brings the protactinium 234-M
24 daughter to the surface and it increases the beta
25 dose. Now we know from operations at Fernald,

1 that was normally cut off of the billet before it
2 was sent out. But still, just to be claimant-
3 favorable, make sure we haven't under-estimated a
4 potential dose, we're not going to use this for
5 skin or for the other two organs for which the
6 skin dose calculation becomes a surrogate in the
7 dose calculation procedure, which includes female
8 breast and testicular cancers.

9 Okay. So that's it. So that's a brief
10 synopsis of where we are and where we're going.

11 **DR. ZIEMER:** Thank you very much, Richard.
12 Let's open the floor for some questions here.
13 Okay, Jim Melius.

14 **DR. MELIUS:** Yeah, I've got a few questions.
15 For the -- I think you referred to it as the
16 supplemental teams, you have two of them, and --

17 **DR. TOOHEY:** Well, no, I have one team now.
18 We're hoping to establish two more, but we're
19 running out of dosimetrists out there who need a
20 job.

21 **DR. MELIUS:** Okay. Well --

22 **DR. TOOHEY:** We're competing with NIOSH to
23 hire the same people. I stole one from them,
24 they stole one from me, so we're even.

25 **DR. MELIUS:** Okay. What is the -- assume

1 that's -- this program's just started?

2 **DR. TOOHEY:** Within the last couple of
3 months.

4 **DR. MELIUS:** Okay. Do we have any idea on
5 what the productivity of that group will be?

6 **DR. TOOHEY:** They do about one or two a week.

7 **DR. MELIUS:** Okay.

8 **DR. TOOHEY:** Simply because without the
9 technical basis document, they have to go do all
10 the records research independently. It hasn't
11 been done and digested for them, so it's not a
12 high volume.

13 **DR. MELIUS:** Okay. And second question I
14 have is -- to finish you was the efficiency
15 protocol -- the first one I believe it was, which
16 was --

17 **DR. TOOHEY:** About likely compensable?

18 **DR. MELIUS:** Right. What happens to people
19 that don't fall -- that don't pass that, they go
20 back into the queue?

21 **DR. TOOHEY:** They go back into the regular
22 dose reconstruction pool.

23 **DR. MELIUS:** Okay, I was just curious on how
24 that worked.

25 Finally, at the last meeting I brought up the

1 issue of posting the conflict of interest...

2 DR. TOOHEY: Yeah.

3 DR. MELIUS: Where does that stand --

4 DR. TOOHEY: Every --

5 DR. MELIUS: -- in terms of that being done,
6 and then secondly, what about for all these other
7 subcontractors and so forth, all this new
8 personnel you've added?

9 DR. TOOHEY: If I may coin a phrase, to the
10 best of my knowledge and belief, the bio sketches
11 and conflict of interest statements for everybody
12 involved in performing, reviewing or supervising
13 dose reconstructions and other key people -- you
14 know, the task managers, the team leaders -- are
15 posted on our web page.

16 DR. MELIUS: Okay.

17 DR. TOOHEY: Now as for everybody involved in
18 the project, we do not contemplate doing that.

19 DR. MELIUS: Okay. What about for the -- all
20 these subcontractors? I don't remember who are
21 key people or what the definitions were, so...

22 DR. TOOHEY: All right. Again, we hadn't
23 contemplated doing that.

24 DR. MELIUS: Had or had not?

25 DR. TOOHEY: Had not.

1 **DR. MELIUS:** Why not? Is there a reason?

2 **DR. TOOHEY:** Because they're not directly
3 involved in dose reconstruction, which was the
4 essence of the conflict of interest requirement.

5 **DR. MELIUS:** Yeah, but don't you think that
6 -- seems to me that I -- we haven't heard the
7 full process. I guess Jim Neton's going to be
8 talking about it later, but it seems to me, from
9 the way you're describing it, that they --
10 they're certainly very influential in doing dose
11 reconstructions, if not doing them directly.

12 **DR. TOOHEY:** Well, the data they produce
13 certainly is influential. But don't forget, it
14 goes through two independent reviews and -- one
15 internally by the ORAU team and externally by
16 NIOSH for approval.

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

18 **DR. TOOHEY:** And we think that's an adequate
19 way of -- what's that word -- vetting that data
20 or what they come up with.

21 **DR. MELIUS:** So you're thinking that it -- I
22 still -- I guess -- my question would still be
23 why not make that information available so that
24 people would know?

25 **DR. TOOHEY:** But we did not propose that in

1 the contract, so -- or the proposal, so that's
2 why we're not doing it. But --

3 **DR. MELIUS:** You'd have no objection to --

4 **DR. TOOHEY:** -- like everything else, it can
5 change. Well, like everything else, it'll take
6 time and cost money, but...

7 **DR. MELIUS:** NIOSH have any response on that
8 or -- Larry, or do we want to talk about it later
9 when Jim's presenting?

10 **DR. ZIEMER:** Larry?

11 **MR. ELLIOTT:** No, I have no response on that.
12 We'll take it under consideration -- take your
13 comment under consideration. We are very adamant
14 that all of the dose reconstructors have their
15 bio sketches up on the web site. I'm not sure
16 that we see the need to go farther than that in
17 this case, so we'll take your comment under
18 consideration.

19 **DR. MELIUS:** Okay. Well, I'll have some more
20 questions then later. Thanks.

21 **DR. ZIEMER:** Thank you, Jim. Thank you,
22 Larry. Other -- Okay, Mike Gibson.

23 **MR. GIBSON:** So are you saying that there can
24 be people doing the site profiles that have a
25 past history at the site?

1 **DR. TOOHEY:** Absolutely, that was in our
2 proposal. We have to use people who have
3 experience at the site 'cause they knew what was
4 going on there.

5 **MR. GIBSON:** But yet it's not necessary, in
6 your opinion, to give a background and their
7 potential conflict of interest.

8 **DR. TOOHEY:** Well, we didn't put that in the
9 proposal.

10 **DR. ZIEMER:** Okay. Robert Presley.

11 **MR. PRESLEY:** Do you have a procedure for
12 somebody that is terminally ill, say from one of
13 these other sites?

14 **DR. TOOHEY:** Oh, there is -- there is a --
15 oh, what's the word -- compassionate processing
16 that NIOSH has. My understanding -- and maybe
17 the OCAS folks could reply to that. It pushes
18 them to the head of the queue to capture their
19 interview, primarily. It doesn't necessarily
20 mean the actual dose reconstruction itself is
21 accelerated, depending on the quality of the data
22 and if it can be done without the site profile
23 being completed. But let me also mention, the
24 supplemental dose reconstruction teams, they
25 would also have the task of doing a special

1 processing as required by the client.

2 MR. PRESLEY: Thank you.

3 DR. ZIEMER: Okay. Mark?

4 MR. GRIFFON: I have some follow-up questions
5 also on the conflict of interest question, but I
6 think I'll hold that for after Jim presents.

7 Shifting gears a little bit, I'm interested
8 in this system you have with the 300 computer
9 users and is Privacy Act information exchanged
10 across that network --

11 DR. TOOHEY: Yes, yes --

12 MR. GRIFFON: -- and if so, can the Board --

13 DR. TOOHEY: -- but not -- but not --

14 MR. GRIFFON: -- possibly use the same
15 network?

16 DR. TOOHEY: -- but not by e-mail. Okay?
17 It's --

18 MR. GRIFFON: Right, right.

19 DR. TOOHEY: -- you know, through dedicated
20 lines using what are sort of standard security
21 protocols.

22 MR. GRIFFON: Right.

23 DR. TOOHEY: (text redacted - four lines - per
24 NIOSH, OCAS.) But basically -- well, yeah, we can
25 give anyone who needs it and, with NIOSH

1 approval, make them a user on the network and
2 give you the -- what's called remote desktop
3 software that enables you to get in, if that's
4 something that NIOSH decides they want us to do.

5 **MR. GRIFFON:** All right.

6 **DR. TOOHEY:** Sorry about that --

7 **MR. GRIFFON:** That's for a later discussion
8 for the working group discussion --

9 **DR. TOOHEY:** Yeah.

10 **MR. GRIFFON:** -- but follow-up on the
11 efficiency process --

12 **DR. TOOHEY:** Let me say one thing, though.
13 The vast majority, if not all, of the data that's
14 out on our network is also on NIOSH's system. So
15 having access, if you get it, into their network
16 would give you essentially the same thing.

17 **MR. GRIFFON:** And a couple of questions on
18 the efficiency process or protocol. You -- I saw
19 maximum internal doses for these steps. Did you
20 consider maximum external doses in these cases?
21 I noticed you talked about missed dose. There's
22 quite a bit of discussion about unmon--
23 potentially unmonitored dose, and did you look at
24 using, as one of the efficiency protocols,
25 assigning maximum internal and maximum external

1 and seeing how the cases fell out, as opposed to
2 just maximum internal plus --

3 **DR. TOOHEY:** Uh-huh, well --

4 **MR. GRIFFON:** -- missed dose.

5 **DR. TOOHEY:** But right now we're doing the
6 maximum missed dose. Now the question comes up,
7 what could the maximum unmonitored external dose
8 have been? Well, it could be almost anything up
9 to something that would cause acute radiation
10 syndrome, theoretically. So we haven't gone in
11 that direction yet. We're going on maximum
12 missed dose for monitored employees. For
13 unmonitored employees -- and that's a fairly
14 small fraction, say of the work force at DOE
15 sites. We haven't really nailed that down yet.
16 But it's certainly possible and it's very similar
17 to the approach with uranium. A maximum uranium
18 intake that would put you in acute kidney
19 failure, we could give you -- I don't know -- 100
20 rem external would start causing blood dyscrasias
21 and -- and if it's still non-compensable. But
22 you know, if you get up to too high a dose, then
23 everything falls out because it then becomes
24 potentially compensable and --

25 In fact, we -- just one story. There was a

1 question at Savannah River about what point in
2 time they were using a mobile photofluorographic
3 unit in the 1950s for routine chest X-rays, and
4 that's one to one and a half R a shot, and that
5 was kicking a lot of these, if we assume maximum
6 dose from that, into a compensable range, which
7 knocks them out of the efficiency protocol.

8 **MR. GRIFFON:** Yeah, and there -- there's more
9 detailed questions -- I mean I understand that,
10 but also I think you could consider the -- the
11 monitoring records over time, the external
12 monitoring records over time --

13 **DR. TOOHEY:** Well --

14 **MR. GRIFFON:** -- to maximize your maximum.

15 **DR. TOOHEY:** Yeah.

16 **MR. GRIFFON:** You don't have to say, you
17 know --

18 **DR. TOOHEY:** And we've got --

19 **MR. GRIFFON:** -- lethal doses.

20 **DR. TOOHEY:** You know, we're getting into
21 area monitoring records and also, as we get more
22 and more claims done, then we can use coworker
23 data also to bracket that, I think.

24 **MR. GRIFFON:** All right, that's what I was
25 going -- and -- and for the maximum internal dose

1 -- and maybe this is specific for Savannah River,
2 but how did you capture -- it talks about the
3 five maximums -- intakes for each radionuclide --
4 or the primary radionuclides of interest. How
5 was that determined? What -- what resources,
6 what data did you use to determine that?

7 **DR. TOOHEY:** Basically it was Savannah
8 River's own monitoring records and incident
9 reports.

10 **MR. GRIFFON:** Okay. And -- and were those in
11 any way -- do -- does ORAU or the -- the site
12 profile teams, are you attempting to verify
13 those? I mean I imagine these are from bioassay
14 monitoring records or incident reports --

15 **DR. TOOHEY:** Primarily they were from
16 incident re-- you know, the existence of a high
17 intake usually comes off an incident report.

18 **MR. GRIFFON:** Uh-huh.

19 **DR. TOOHEY:** You know, glove box blows or
20 something --

21 **MR. GRIFFON:** Right.

22 **DR. TOOHEY:** -- so there's a potential. But
23 then the quantification of the intake comes from
24 the bioassay data. Now what we didn't do, though
25 -- again to be claimant-favorable -- was use the

1 old lung and metabolic models to work back to the
2 intake, which is in fact claimant favorable.
3 It's generally a higher estimate of the intake
4 than using the newer models. And comparison of
5 the models and the resulting predicted maximum
6 intakes are in that technical basis document --
7 or technical information bulletin.

8 **MR. GRIFFON:** Okay. So these maximums would
9 have been based on reported incidents primarily -
10 -

11 **DR. TOOHEY:** Right.

12 **MR. GRIFFON:** -- from the -- from the data
13 provided by the Department of Energy site.

14 **DR. TOOHEY:** Right.

15 **DR. ZIEMER:** Could you clarify for me the
16 types of individuals who worked on a site who may
17 now be involved in these site profile? For
18 example, is it conceivable that an individual who
19 at one time in the past was responsible for
20 generating some of the data which is now used in
21 the profile would be on a site --

22 **DR. TOOHEY:** Yes.

23 **DR. ZIEMER:** -- team and -- and at least
24 perception-wise, be defending data that that
25 individual developed in the past? Do you

1 understand the nature of the question I'm asking?

2 **DR. TOOHEY:** Yeah, sure, I do. And the short
3 answer is yes. I'll give you a couple of
4 examples. One of our key subcontractors looking
5 at external dosimetry data is Jack Fix, who
6 probably knows more about external dosimetry
7 across the DOE complex than anybody else. So did
8 -- was he responsible for generating some of the
9 data? Yes. Is he defending that data now? I'm
10 not sure if that's what he's doing. He's
11 providing it, and then it's subject to scientific
12 review and analysis by people who did not
13 generate it.

14 **DR. ZIEMER:** Give us an idea of the
15 composition of a typical team you're using, and
16 it's clear that we want to mine the information
17 from those who are very knowledgeable, and yet
18 questions might arise -- I think they've been
19 hinted at, that one might become defensive about
20 one's own past data.

21 **DR. TOOHEY:** Sure.

22 **DR. ZIEMER:** So what --

23 **DR. TOOHEY:** Well, the --

24 **DR. ZIEMER:** What is the mix of sort of
25 outside independence on a team?

1 **DR. TOOHEY:** The typical team is about a half
2 a dozen people, would you say, Judson? Okay,
3 Judson Kenoyer's here, who is our task three team
4 leader, and will have some more input on that
5 later. In general the people on the team for the
6 site probably -- I would say -- it's fair to say
7 in general probably did not work themselves at
8 the site. The people who did or still do work at
9 the site are used as resources for the team. Now
10 Jack's one exception. He's -- he did the
11 external dosimetry part of the Savannah River
12 document and he's doing the one for the Hanford,
13 and of course he did work there. But for the
14 internal part of Savannah River, our primary
15 resource for that data was Tom Labone at Savannah
16 River. So he was -- I don't know, a consultant
17 may be too strong a word -- a data source for us
18 to use, but he was not actually on the team that
19 produced the document.

20 And Judson, do you want -- would you like to
21 comment on that?

22 **MR. KENOYER:** I'd like to add just a few
23 words to that. As we put together these teams,
24 we are trying to gather groups of people that
25 basically had experience working at those sites.

1 They may or may not have been employees of the
2 contractor on-site. Perhaps they were a
3 subcontractor that had done work. With the idea
4 that we needed to gather five or six people that
5 had different areas of expertise, also --
6 internal dosimetry, external dosimetry, if they
7 knew anything about the X-ray systems used. So
8 it's a matter of trying to pull together a good
9 cohesive team that had experience, that perhaps
10 knew people that still worked on that site, or
11 people that had retired, so...

12 **DR. NETON:** I'd just like --

13 **DR. ZIEMER:** Thank you. Jim Neton.

14 **DR. NETON:** I'd just like to add one extra
15 piece of information. Each one of these teams
16 has an assigned NIOSH health physicist who serves
17 as a technical monitor --

18 **DR. TOOHEY:** Good point.

19 **DR. NETON:** -- of the technical basis
20 document or site profile for all 13 or whatever
21 currently ongoing. In fact, before it ever even
22 goes through formal review, I have a little slide
23 that'll demonstrate this, it is -- it is
24 essentially vetted by the NIOSH technical monitor
25 or worked with side-by-side until -- and then it

1 comes to NIOSH for review, and it is a document
2 that is both reviewed by ORAU and reviewed and
3 signed by NIOSH, issued as a controlled document.
4 So NIOSH ultimately approves the technical basis
5 document, not the person who may have worked at
6 that site.

7 **DR. ZIEMER:** Thank you for that
8 clarification. I think Mike Gibson has a
9 comment.

10 **MR. GIBSON:** How many of these teams has a
11 former field worker, such as a craftsman,
12 involved in them, or maybe a current field worker
13 such as a craftsman, that escorts them, that asks
14 them have you looked at this event, have you
15 looked at this potential event. That's one
16 question.

17 The second question is if an event happens
18 and it's found out about later and the report is
19 generated later to where bioassay data wouldn't
20 be adequate, how do you determine the dose to the
21 employee?

22 **DR. TOOHEY:** Okay. Well, first -- first
23 question, to my knowledge, we don't have any
24 crafts or trades people on these teams. They're
25 all health physicists.

1 Second question, if incident occurred but was
2 realized later, when it's below say the limit of
3 detection of bioassay so you can't back-calculate
4 to what the intake may have been, then you would
5 have to work off any available data you do have -
6 - air monitoring, surface contamination levels,
7 skin contamination, levels on workers present,
8 whatever you can get. And there are ways of
9 converting air monitoring data to release and
10 resuspension factors and all those sort of
11 things, so we can bracket what the potential
12 exposure could have been. And remember in this
13 case we're trying to determine what the maximum
14 could have been, not what the actual intake was.
15 So all the way through that process in trying to
16 back-calculate, we make the claimant-favorable
17 assumptions to try to maximize the dose.

18 **MR. GIBSON:** And a third question, are you
19 going back and when you're looking at the MDA for
20 the different sites, are you also going back and
21 looking at whether the QC that they've used to
22 calibrate their systems and whether they've been
23 fined by Price-Anderson* for elevating the MDAs
24 to artificially high doses?

25 **DR. TOOHEY:** We certainly look at the

1 historical MDA. And in fact that's one of the
2 things in this process, like many others, which
3 takes more time than we thought it would is going
4 back -- I think Dr. Neton's presentation will
5 talk about that. A lot of the notations in the
6 records are extremely cryptic. For instance, we
7 found whole-body counting records from Savannah
8 River where the activity designations are A, B,
9 C, D. It took us a while to find out what that
10 meant. It turned out it actually referred to
11 energy bands in the gamma ray spectrum. But
12 yeah, we do. We try to go back, look at the QA
13 records. And the calibration records, it's
14 especially important on the external dosimeters,
15 and we have had people looking at that. And part
16 of our uncertainty analysis team is also
17 specifically looking at that, also. Peter
18 Groher* from the University of Tennessee is
19 heading that effort up.

20 **MR. GIBSON:** And just one -- one thing for
21 the record is, you know, I'm not questioning
22 anyone's credibility here. I want to make the --
23 this is a thorough and proper process. Let's not
24 forget we wouldn't be sitting here, this law
25 wouldn't be on the books if the Department of

1 Energy had done its job right. I just want to
2 make sure that, now we're trying to correct the
3 problem, we do it fairly.

4 **DR. ZIEMER:** Thank you, Mike. We'll have one
5 more question and then Rich, if you would be
6 available later in the morning, obviously this is
7 of great interest and maybe when we get to your
8 regular time slot we can have an opportunity to
9 reopen things. But we do have a guest speaker
10 who will have to be leaving mid-morning and we
11 want to allow him to give his presentation before
12 the plane leaves. So I'll allow one more
13 question. Jim, and then we'll --

14 **DR. MELIUS:** I believe this is a brief one.
15 My understanding is at the last meeting -- I was
16 not present the second day -- that Larry Elliott
17 had talked to the Committee about relaxing the
18 conflict of interest rules for the people doing
19 the individual dose reconstructions. Has that
20 been done or what's --

21 **DR. TOOHEY:** No. We felt the consensus of
22 the Advisory Board was that was not a good idea,
23 so we have not pursued it.

24 **DR. MELIUS:** Okay. Thank you.

25 **PRESENTATION BY DR. JOHN TILL, RAC**

1 **DR. ZIEMER:** Thank you very much. Our next
2 agenda item is a guest speaker, Dr. John Till.
3 Dr. Till is president of Risk Assessment
4 Corporation. I want to give a little bit of
5 biographical information. I'm not sure if --
6 it's not in your book, so let me -- John, I'll
7 try not to use up too much of your time, but you
8 have such an important resumé I want to give a
9 little bit of that.

10 John is a graduate of the U.S. Naval Academy,
11 served in the U.S. nuclear Navy submarine
12 program. He retired from the Navy in '99 as a
13 Rear Admiral. He's a recipient of the
14 Distinguished Service Medal, Legion of Merit, a
15 couple of Navy Meritorious Service medals and
16 other commendations. Dr. Till is -- has been a
17 recipient of the Ernest Lawrence Award, which is
18 an award of the Department of Energy in the field
19 of environmental science and technology.

20 In 1977 he formed a company called the Risk
21 Assessment Corporation -- I think originally it
22 was called Radiological Assessment Corporation --
23 and since its formation that group has played a
24 very key role in the evolution of methodologies
25 for environmental risk analysis.

1 John served as Chairman of the Technical
2 Steering Panel for the Hanford Environmental Dose
3 Reconstruction Project. He's been principal
4 investigator in the successful completion of
5 Fernald Feed Materials Production Center
6 Historical Dose Reconstruction Project. He's
7 been involved in Phase II at the Rocky Flats
8 Plant Dose Reconstruction Process, Phases I and
9 II of the Savannah River Dose Reconstruction
10 Project, and there are a number of others, so you
11 get the point.

12 John's very well-published. He has over 175
13 publications. He edited the first book on
14 radiation dose analysis called *Radiological*
15 *Assessment*.

16 He's currently a member of the ICRP,
17 International Commission on Radiological
18 Protection. He's Chairman of the National
19 Academy of Sciences review committee that
20 reviewed the dose reconstruction program of the
21 Defense Nuclear Threat -- Defense Threat Nuclear
22 Agency, and we're going to hear about that
23 shortly.

24 **DR. TILL:** Paul, that's enough.

25 **DR. ZIEMER:** I left out the most --

1 **DR. TILL:** That's enough.

2 **DR. ZIEMER:** -- the most important thing,
3 John, to you. John is also a farmer. I think --

4 **DR. TILL:** That's important.

5 **DR. ZIEMER:** -- originally was a dairy
6 farmer, still has that big farm and loves
7 farming, as well.

8 **DR. TILL:** That's --

9 **DR. ZIEMER:** John, welcome.

10 **DR. TILL:** -- the most important thing, the
11 last. I am a farmer and I love it. And I am
12 very honored to be here and speak with you. I've
13 heard quite a bit about your work. Thank you
14 very much, Larry, for your gracious invitation.
15 And Paul, what should I do, try to quit at 10:00
16 or do I have a bit more time? Well, I won't take
17 longer than you've allowed me, but maybe we
18 should set up a few ground rules.

19 I would encourage you to stop me at any time
20 if you have a question, and let's talk. And if
21 we see we're getting hung up too much and I'm not
22 getting through some of the key points I'd like
23 to make, then we'll change the course of action,
24 if that's all right.

25 A few things I need to say from the outset

1 this morning is that I'm not speaking for the
2 National Academy. I'm speaking for myself. And
3 that's important because I think I want to say a
4 few things that probably are not in the Academy
5 report, and I may point those out to you as we
6 go.

7 The report itself will be published on
8 Friday, and I spoke with the Academy last week
9 and I asked them, Paul, to be sure and send you
10 copies. I said send Paul Ziemer as many copies
11 as you can. I think they're aware of your
12 committee and hopefully they'll do that, but it
13 should be published this Friday. It has been on
14 the web, as you know, and that's what I want to
15 focus on is the Academy report, but throwing in a
16 few other personal comments, if you don't mind.

17 The Academy report was a great privilege for
18 me. It was the first time I'd chaired an Academy
19 committee. I've served on many of them, but I'd
20 never chaired one before. We took two and a half
21 years to do the work.

22 I want to also make sure that you understand
23 that what I say this morning is not intended to
24 be critical of any individual, any organization,
25 whatsoever. And not that what I say is caustic

1 in any way, but I think we sometimes forget how
2 science evolves and how we evolve as people and
3 what we do and what you're doing right now, for
4 example, is quite revolutionary. And I can
5 guarantee you one thing, and that is after you've
6 been here for a number of years -- and Dick,
7 after you've done this work for a number of
8 years, anybody can come in and tell you what you
9 did wrong from the beginning and what you're
10 doing wrong and how to make it better. And don't
11 forget that. And don't forget to convey that
12 message to the claimants, I guess that's the
13 proper term, that we're getting better at this
14 all the time. And right now, frankly, we're in
15 our infancy with regard to this science, and
16 probably with regard to what you're trying to do,
17 which is to administer a law that this country
18 saw fit to put into place.

19 I'm going to stop occasionally and look at my
20 notes to be sure I'm covering things 'cause I'm
21 sure I'm going to get off track here from time to
22 time. I have no presentation. I did that
23 deliberately. I'd rather you listen to what I
24 have to say. Much of what I have to say you can
25 read, and I really encourage you to read this

1 report that is going to come out this week.

2 I want to say one thing in particular about
3 the Academy and the Academy's work, and it's
4 directed to Mike Schaeffer who's back there.
5 Mike, I really commend you. And I have been
6 reviewed by the Academy -- in fact, almost all of
7 my work for 15 years has somehow gotten into the
8 channel of Academy review. And frankly, I've
9 found it downright annoying that you can bring in
10 this group of experts to sit around the table,
11 who suddenly -- after you've been doing the work
12 for three, four, five years and you've put
13 together this magnificent report, that these
14 experts who suddenly come in think they can pick
15 up in just a matter of meetings everything that
16 you've done and tell you what you've done wrong,
17 and very seldom compliment you on what you've
18 done right, I found very annoying.

19 On the other hand, it was also refreshing. I
20 also learned. I had the opportunity to look at
21 what they recommended and say you're right or
22 wrong, and in some cases, the Academy was
23 downright wrong about what they said, and we
24 challenged them on it. And at least I felt
25 better afterwards. But I think it is the

1 character of how you accept the recommendations
2 of the Academy, or any other high and mighty --
3 almighty group.

4 And Mike Schaeffer, you have done this
5 magnificently. I know that you've taken on many
6 of the recommendations already. I don't know
7 specifically, but I've heard incredibly good
8 things. Plus I think DTRA, SAIC, the VA, were at
9 an incredible disadvantage to what you have, and
10 that is they did not have this knowledge and they
11 had a program that was 20 years old. And it
12 really took about 20 years before some outside
13 group, like us, came in and looked at their
14 program in the depth and thoroughness that we
15 did. So I want to personally congratulate you,
16 Mike. But all the others at SAIC, at J-Corps and
17 the VA, as well. Tony Princippi has also been
18 very responsive to what we said.

19 It wouldn't be fair for me not to mention the
20 other committee members -- Harold Beck, Jay Brady
21 -- and if you don't know Jay Brady, he is quite a
22 character, a wonderful man to serve with, with
23 incredible experience -- first-hand experience at
24 the testing site -- Tom Giselle, David Hoyle,
25 Eric Kearsley, Dave Kocher -- Dave's here --

1 yeah, he's going to keep me on track here this
2 morning -- Jonathan Merino, who's a bioethicist,
3 and I'd never worked with a bioethicist before on
4 a scientific committee, but what a wonderful
5 contribution Jonathan made to our work; Clair
6 Weinberg, as well. And of course Evan Dupole and
7 Esoph at the Academy, just an incredible group of
8 people to work with.

9 As I accepted this job with the Academy to
10 chair this committee, I knew it was going to be a
11 difficult task because I had been involved in
12 dose reconstruction work for quite some time. I
13 know how tedious it is. I know how complex it
14 is. I know how much information is always
15 missing, usually far more than you have to work
16 with. And so it was with some bit of concern
17 that I accepted the job as Chair.

18 I was also a bit familiar with what DTRA was
19 doing, and the veterans' programs, but not in
20 great depth. And the reason I was somewhat
21 familiar with it is because I had an opportunity
22 to serve on one of the Academy reports, the five
23 series study. It was an epidemiological
24 analysis, looking at disease among some of the
25 atomic veterans in five different series to see

1 if we could see an effect. When we started that
2 work we hoped to be able to assign specific doses
3 to the different cases. And I was asked to lead
4 a small task group in the work, and that was to
5 decide whether or not the dosimetry that had been
6 developed over the years by DTRA could be used in
7 fact in the epidemiological analysis. And the
8 conclusion of that small group was that we could
9 not, that this dosimetry was not suitable for
10 epidemiology. And that's the first point that
11 I'm going to make with you today that I hope
12 you'll remember, and it's not in the Academy
13 report.

14 I want to challenge you, I want to challenge
15 this panel, I want to challenge the scientists
16 who are working on this, and I'd like to
17 challenge NIOSH to make sure that what you're
18 doing in this study is not merely fulfilling the
19 law. But let's advance the science. Do not miss
20 an opportunity to let's push the science a notch
21 -- more than a notch.

22 I'll mention a couple of things as I talk
23 this morning where I think those opportunities
24 might exist. I know that you're open to this,
25 but let me encourage you that -- let me tell you,

1 in my opinion as a scientist and as a taxpayer,
2 it is not sufficient to merely fulfill the law.
3 We've got to raise the level of the science that
4 we're working with. As you get into this you're
5 going to realize how little we know about dose
6 reconstruction, how little we know about the
7 exposure situations that occurred, or even how
8 little we know about the validity of what you're
9 trying to do. That is, to compensate people
10 based on these calculations.

11 So the point there is I had some insight as
12 to what I was getting into before I started this,
13 but I had no idea how complicated it was
14 ultimately going to be.

15 You should know that this Academy report does
16 not deal at all with the idea of compensation.
17 Whether it's good or whether it's bad and whether
18 you agree with it or don't agree with it, or
19 whether we agreed with it or did not agree with
20 it as scientists had nothing to do with the
21 report or what we did. We were there to decide
22 whether or not the science was being done and the
23 law was being fulfilled. So we could not and you
24 cannot allow personal feelings to get involved in
25 what you do.

1 So the approach that we took to the work was
2 that we knew we were stepping into a situation of
3 volatility and a lot of visibility with the
4 Academy report. And I think this Academy -- I'm
5 not certain about this, but I think this Academy
6 committee did break some new ground with regard
7 to public involvement. I know they've been
8 working at this for a long time. If you work
9 with the Academy, you know it's a quite closed
10 organization. They have incredibly strict rules
11 for how they work.

12 But on the other hand, we thought it was
13 important to meet the veterans, to have the
14 veterans talk to us, to go to them on their turf
15 -- which we did. We wanted to be sure that what
16 we did was thorough and defensible. Did we
17 accomplish that? I don't know. Time will tell.

18 So in the beginning we set a course to do
19 several things. We were actually obligated with
20 our charge, which I'll come back to in a few
21 minutes, to develop a statistically significant
22 sample from which to work. At the time we began,
23 there were about 3,700 dose reconstructions that
24 had been performed. We decided to take a sample
25 of 99. We felt that was statistically

1 significant. About two-thirds of those we wanted
2 in the higher dose category, so we said they had
3 to be a dose above one rem. But we were also
4 concerned that if we did that, we would neglect
5 one very important group and that were the
6 veterans from the Hiroshima/Nagasaki, either
7 prisoners of war or service men and women who
8 served in Japan following the A-bomb tests. So
9 we took a separate sample of those. That was
10 about ten. So we were working with about 110 of
11 our own selected -- randomly selected samples.
12 But in addition, we encouraged veterans who
13 wanted to to send us their files. We got about
14 two dozen of these. And we did work a number of
15 these files and we found them quite interesting,
16 and some very supportive information for our
17 report.

18 So how did we do this? We set out, for about
19 the first year and a half, aggressively reviewing
20 these files. Every committee member looking at
21 every file, and that takes time -- a lot of time
22 -- to go through each file, to try in your own
23 mind to decide do you understand what's being
24 written here, do you agree with what's being
25 written here, what are your problems.

1 So a few other things we wanted to do as we
2 drafted this report, we wanted it to be
3 understandable by Congress, by scientists and by
4 the veterans -- and by anyone else who might read
5 it. Now did we achieve that goal? Probably not,
6 but I do believe that a lot of what we did is
7 understandable. I mean I will tell you that when
8 you read a couple of the chapters, you may get
9 lost. I mean even we did, as we go through this
10 from time to time. We had some very bright
11 people who were working on this. However, I
12 think as a whole, when you look at the report,
13 everybody can get something out of this. And
14 there are parts of this report deliberately
15 written in the language where we hoped the
16 veterans would understand what we're saying.

17 We wanted to be detailed, very detailed, and
18 I challenged the members of the committee as we
19 drafted this report to be specific, to put case
20 numbers down so that anybody who wanted to go
21 back, these cases are available -- not the names,
22 but the cases. So anybody who wanted to go back
23 and see what we were talking about could
24 certainly do that.

25 We wanted not only to show what we thought

1 was incorrect or weak, but the strengths of the
2 work. And where something could be done more
3 correctly, we wanted to show DTRA or the
4 scientists working on this how they could do it
5 better.

6 So just briefly, when you see the report
7 you'll see an introduction. You'll see a chapter
8 on the process of the committee that explains
9 basically what I just told you now. You'll see a
10 chapter on the process for claims, how does a
11 veteran file a claim and exactly what are the
12 steps that it goes through. Believe it or not,
13 that was very difficult to sort out. The
14 graphics that you see in this report, we
15 developed, because there was not a single graphic
16 that the VA could bring in, that DTRA could bring
17 in that showed the entire process -- at least not
18 clearly. I'm sure -- I'm sure we had some
19 examples to work with.

20 There's a chapter on the dose reconstruction
21 process and what that does. It focuses on how we
22 saw the process being done, without the critique.
23 This is the way it was being done. These are the
24 steps being followed. These are the assumptions.
25 These are the models being used.

1 And then there's a chapter on findings, so if
2 you're doing it this way, what's good, what's
3 bad. Here's how we recommend solving problems
4 you might have.

5 And then a very key chapter, and I'll talk
6 about a few of these as we go through this this
7 morning, where we had other findings. Not
8 strictly dose reconstruction, but things related
9 to dose reconstructions. And I have to tell you
10 as I read the charge in a few minutes, you're
11 going to think wow, that's pretty restrictive.
12 We were very broad in interpreting our charge.
13 And I think this committee went as far as an
14 Academy committee can go to give -- to give DTRA,
15 to give the Congress, to give the veterans more
16 than what we were asked in the charge. And I
17 hope we did that. In fact, we probably -- we
18 tried to go a little farther in some cases and we
19 felt that it was inappropriate, but other
20 findings like communication with the veterans;
21 the bioassay program that DTRA had instituted
22 something called the low level dose screen, which
23 was a huge credibility issue; and what are the
24 implications to the veterans of what we're
25 saying. And then we had conclusions and

1 recommendations. You'll see all of this when you
2 look at the report. If you have any trouble
3 getting these, Paul, give me a call, please.

4 We were also confronted, when we began the
5 work, with the fact that the Academy has looked
6 at the veterans before. Now that's interesting,
7 isn't it? In fact, in 1985 the first Academy
8 report on the mortality of nuclear test
9 participants, there were some problems in that
10 report with numbers and so forth in 1985, and
11 that work was ultimately redone. In 1985 there
12 was a report by -- that Merrill Eisenbud shared
13 on methods. That's interesting. 1989, a very
14 solid report that Frank Massey chaired on
15 external dosimetry. In 1996 an Institute of
16 Medicine mortality of participants, that was sort
17 of a repeat of the earlier work looking at -- it
18 was an epidemiological study. In 2000, the five
19 series study that I participated on. So what
20 happened? So why is what we're doing so new and
21 different?

22 Well, the problem is that the right questions
23 were not asked before. That's one problem. And
24 in great respect to Merrill Eisenbud, in 1985
25 when he looked at this, this science, this

1 business of dose reconstruction, was really in
2 its infancy. And Merrill and his committee
3 pointed out some very serious issues that we
4 still found when we looked at this work.

5 But the point I'm making here, and it is
6 important because you need to challenge those who
7 are going to verify what's being done, be sure
8 you're asking the right questions, or you won't
9 get the answers that you're looking for.

10 I also believe that in the work that we did,
11 no other committee -- no other Academy committee,
12 aside from the fact that they didn't have the
13 explicit charge that we had -- and this may not
14 be a fair statement and I might have to qualify
15 it -- but did not look with the thoroughness and
16 aggressiveness that this committee looked into
17 with regard to these doses. And it's certainly
18 not fair to say that about the epidemiological
19 studies, but perhaps they never had an
20 opportunity.

21 You need to know something about the history,
22 and this is important, of the history of that
23 program because there's a point I want to make at
24 the end, and I'm not going to say much. But this
25 started a long time ago, this issue with atomic

1 veterans and disease and the concern about
2 disease and the dose reconstruction program has
3 been in place for a long time, over 20 years this
4 has been going on -- 25 years when you look back.

5 In 1977 when there was reported an increase
6 in leukemias among participants at Shot Smoky*
7 and that was Glen Caldwell's work, and I think
8 that was the report that first elevated the
9 concern about exposures of veterans.

10 In 1998 Congress authorized the NTPR program,
11 and that was really to start pulling the
12 information together on the veterans. And thank
13 goodness at that time Congress did act, because a
14 lot of the records it's possible might not be
15 with us today, or might not have been retained.

16 And also in 1978 DTRA and -- well, it was DNA
17 at that time -- was responsible for determining
18 or looking into VA eligibility. In 19-- for
19 compensation.

20 In 1981 the first public law was passed. In
21 1984 the law was amended, and that's when we
22 really got into the dose reconstruction process,
23 about that time, so that doses had to be
24 calculated.

25 The law has been changed about 15 times. Now

1 why is this important? It's very important to
2 keep in mind that the science is always changing.
3 And so much -- in fact, I'm sure if you're in a
4 different field of science, you'll say that your
5 science has changed just as much as this whole
6 business of dose reconstruction. But by golly,
7 I've been in this for a while now, and I don't
8 know that I know of anything -- other than the
9 medicine field and the phenomenal advances we're
10 making there -- but I don't know of any other
11 area that's changed quite so much -- our ability
12 to grasp information, our ability to do something
13 with huge amounts of data. We couldn't do these
14 things 15 years ago -- ten years ago. And so
15 much even in the last five years.

16 And so as you're critical of what happened in
17 the DOE complex 20, 30, 40, 50 years ago, don't
18 forget that fact. And I think you have to keep
19 in mind that it very well may have been what
20 you're seeing as changes in the science, changes
21 in our expectations of scientists and data
22 management, and not the fact that somebody -- and
23 I heard the comment this morning, and I'm not
24 defending DOE. I -- believe me, I'm not. But on
25 the other hand, somebody said well, they didn't

1 do their job. It's pretty difficult for us to --
2 in my opinion, to make that statement because
3 we're not living in that time. So that's why the
4 history is so important. And it will change. In
5 the next five years and, Larry, by the time
6 you're finished with this task, I can guarantee
7 you what you see today, what you do today is
8 going to be so different.

9 So a question that this leads to, which is
10 also not in our report, so what do you do about
11 the changing science, and what is your policy
12 about changing science? Do you have one? Maybe
13 you do. If you don't, then think about it. What
14 is your position going to be that if you're using
15 ICRP dose coefficients, and I assume that perhaps
16 you are, when those dose coefficients are
17 upgraded over two years of time and maybe the
18 dose coefficient for plutonium inhalation goes up
19 or goes down, so what are you going to do? Are
20 you going to change the science as you go through
21 the process -- and I hope that you will, because
22 that's what my recommendation would be to you.
23 But then what does that lead to? What do you do
24 about doses you've already calculated? What do
25 you do about people that you've already

1 compensated? These are some serious thoughts
2 that I want to leave with you.

3 And I think that was one thing in our report
4 that we didn't feel was handled very well, at
5 least a clear policy on what you do about
6 changing -- changes in the science. And we felt
7 that for -- in a lot of the methods being used,
8 the most up-to-date, the most current information
9 was not being used to calculate doses.

10 Am I going too fast? Are we doing all right?
11 I hope I'm saying something worthwhile to you. A
12 lot of this is off the cuff and not in the
13 report, but what I'm going to do now is shift to
14 the report itself just a little bit.

15 The first thing I want to do is just to
16 mention the charge of the committee. And this
17 was written -- I suspect it was written by
18 Congressional staffers 'cause let me just read
19 the first charge.

20 (Reading) Whether or not the dose
21 reconstruction of the sampled doses is accurate.
22 Isn't that wonderful, the word "accurate"? Is
23 anything we do in this accurate? I don't think
24 so. And so, you know, here you are, the
25 committee, how do you respond to a question like

1 that? Well, we interpreted that question --
2 well, I'll come back to that in just a minute.

3 The second charge was (Reading) Whether or
4 not the reconstructed doses are accurately
5 reported to the VA.

6 The third charge, (Reading) Whether or not
7 the assumptions made about radiation exposure are
8 credible. What does that mean? Whether or not
9 the assumptions made about radiation exposure are
10 credible.

11 And fourth, (Reading) Whether or not the data
12 from nuclear tests used by DTRA as a part of the
13 reconstruction of sampled doses are, again,
14 accurate. Whether the data are accurate.

15 And then the committee was also asked to
16 recommend whether there should be a permanent
17 system of review for the dose reconstruction
18 program. Let me answer that now. Absolutely.
19 Absolutely. And I think if the DTRA program has
20 suffered from anything over the years, it's the
21 fact that there's not been a group like you to
22 take responsibility for advising them on the
23 science and for challenging them, as you have
24 this morning on things like conflict of interest,
25 communication, quality assurance. And so we did

1 recommend that a permanent system of oversight be
2 put into place.

3 Now I think it's important that I just go
4 ahead and hit right now the way we said that. If
5 you saw the report, when we responded to that
6 question we said if the program continues, yes,
7 we think there should be a permanent system of
8 oversight.

9 Now I'm going to go back into the John Till
10 mode and I'm going to tell you what that means.
11 We struggled with value of what was being done,
12 and this is just me talking now, ladies and
13 gentlemen. But I think we have to look at the
14 value of what we are doing, as a country, as
15 taxpayers, some of you perhaps as claimants, the
16 value of what we are doing. What is this costing
17 us overall to administer a program that delivers
18 some benefit to these individuals -- quite
19 deservingly so, but what is it costing us? Now I
20 don't know the answer to what it costs DTRA, the
21 VA. I don't know the answer to that. But I
22 think the committee struggled with the question
23 of value and was what was being done, and the
24 cost of administering this program for 20 years,
25 and what was actually being paid out worth it.

1 I'll give you an example of why this came up
2 -- or at least in my own mind why it came up. We
3 struggled on the committee trying to find out how
4 many individuals out of some 4,000 dose
5 reconstructions that had been performed -- and
6 I've missed talking about the law, and I hope
7 you'll forgive me for that.

8 There's a presumptive law and a non-
9 presumptive law for disease. The presumptive law
10 means that if you have a certain type of cancer
11 and there are about 21 cancers and you were there
12 at a test site, you're compensated. The non-
13 presumptive law accounts for those individuals
14 who don't have the presumptive disease who claim
15 they were there or who have some disease and want
16 to be compensated, and that's when you shift into
17 this mode of the dose reconstructions.

18 So over the time, there were about 4,000 dose
19 reconstructions. And we asked and were very
20 curious to know, well, how many of these claims
21 had been awarded. And so we went to the Veterans
22 Administration and we asked them, and the numbers
23 always came back a little bit different, but on
24 the order of I think 1,500 or 1,600 or something
25 like that. And we were really puzzled because

1 the numbers didn't add up in our sample of 99.
2 We just couldn't see it.

3 And so we did some more investigating into
4 this. It turns out -- and this is another point,
5 but I'm sure you've got this one resolved, Dick
6 and Larry, and that is we wanted to go into the
7 database and punch some buttons and do a query
8 that said out of these dose reconstructions, how
9 many successful claims have been awarded? You
10 couldn't do that. And when you did it, you came
11 up with the numbers that included a lot of other
12 categories and it just couldn't be sorted out.

13 And so what we did, and the VA worked with us
14 because they were really curious. The veterans
15 had been saying for years and years the number
16 was on the order of about 50. The VA was saying
17 on the order of about 1,500, 1,600. Big
18 difference there. Huge credibility issue for us,
19 to be able to sort this out. So we took a sample
20 of 300, looked at them individually. The answer
21 is about 50. And that's the best we can sort
22 this out, about 50.

23 Now whether or not that's good or bad to you
24 has nothing to do with this, but it does, in my
25 mind -- John Till speaking -- raise the issue of

1 value of what we're doing. So I'll leave that
2 thought with you.

3 So what were the answers to our charge? With
4 regard to whether the dose reconstruction of
5 sample doses is accurate, the committee concluded
6 that credible upper bound doses from external
7 gamma, neutron and beta exposure are often
8 underestimated and sometimes considerably. And
9 that's what we reported in the press conference.

10 Now what that didn't say is that the average
11 doses that are calculated are pretty good,
12 especially the external gamma doses. The average
13 doses are pretty good. It was the upper bounds
14 we were concerned about, but the upper bound is
15 what's reported for compensation, and I know
16 you're doing the same thing. And we were looking
17 at a 95th percentile upper bound on the dose
18 calculations.

19 In response to question number two, whether
20 or not the reconstructed doses are accurately
21 reported, the committee concluded that as they
22 have been calculated by DTRA, they have been
23 accurately reported to the VA and the veterans.
24 In other words, we're reporting the numbers that
25 we calculate, even though the numbers we're

1 calculating may not be the correct upper bound,
2 but we are reporting. So the answer to that
3 charge is yes.

4 On the other hand, with regard to reporting
5 information -- and I want to come back to
6 communication before I finish; I'll have to get a
7 few words in about that -- we're doing a lousy
8 job of trying to explain to veterans what these
9 doses mean.

10 And I challenge you to do that to your
11 claimants. And it's tough. From what I know
12 about what you're doing -- what little I know
13 about what you're doing, I think you are making a
14 great effort at this and you are opening your
15 meetings and you are trying to explain to people,
16 for example on a probability of causation, what
17 it takes to get an award -- a successful award.
18 So I congratulate you on that.

19 In response to question three, whether the
20 assumptions made regarding radiation exposure are
21 credible, the committee concluded that many key
22 assumptions and methods being used are not
23 appropriate and often lead to underestimation of
24 the upper bounds of doses to atomic veterans.
25 That is a very difficult charge to respond to,

1 because much of the information -- most of the
2 information is very good data to work with.

3 One key point there -- and I'll come back to
4 this and hopefully can read you a couple of these
5 cases -- is benefit of the doubt. And in that
6 area, we felt this charge -- they didn't meet
7 this charge, in particular because of following
8 with the responsibility of benefit of the doubt.

9 Regarding the fourth question, whether the
10 data used by DTRA to reconstruct the sample doses
11 are accurate, and we interpreted this to mean are
12 the data that we have to work with to reconstruct
13 these doses for atomic veterans, is there enough
14 information there to reconstruct the doses. And
15 if you haven't looked at some of that information
16 that was compiled early on in the NTPR program,
17 it is quite astonishing. It is a wealth of
18 information. And thank goodness Congress, DTRA,
19 took the time to put all of that together at the
20 beginning 'cause it's some good solid data to
21 work with. It's amazing how much information was
22 collected at these tests.

23 I honestly don't know how much you have to
24 work with. And Dick, one of these days we'll
25 have to have a little chat about that, 'cause I

1 think you may be more in the dark -- far more in
2 the dark than DNA when they first started out
3 this work, the information they had to pull
4 together.

5 Okay. So just a few other key conclusions.
6 Quality control was a real problem. A real
7 problem. And as we went through these records --
8 and this is where I'm not trying to be critical
9 of DTRA or any of the contractors that worked on
10 this, but we had a very, very hard time following
11 the logic of the calculations, following the
12 documentation that was there. And in a lot of
13 cases it was -- we just couldn't do it. It was
14 impossible to do. Documentation is absolutely
15 crucial for what you are trying to do. In real
16 estate it's location, location, location. In
17 dose reconstruction it's documentation,
18 documentation, documentation.

19 And how would I address that if I were you?
20 I would -- I would make sure that what you're
21 doing is checked. I heard this morning you're
22 having it checked by a couple of people, which is
23 certainly essential to do. But make sure
24 somebody coming in off the street who knows
25 something about the science, who has not been

1 involved -- intimately involved in this process
2 you're doing, can take those records and follow
3 them. Every assumption that was made and how the
4 numbers were calculated.

5 So one of the other things in the report we
6 thought that this was very important to say, and
7 that is okay, so you read what we have done. You
8 read -- when you read this report you're going to
9 think there's a lot wrong -- perhaps you will --
10 a lot wrong with how the doses were calculated
11 for the veterans. So what does that mean? What
12 are the implications of what we found?

13 We thought it was important to mention that
14 out of the thousands of dose reconstructions that
15 have been filed that if you were to go back and
16 redo all of these dose reconstructions, what
17 difference would it have made in terms of the
18 number of cases or claims that had been awarded.
19 And the answer is, we think it would make very
20 little difference.

21 Now the reason for that is very apparent when
22 you look at the methods we're using, the methods
23 you are using, the probability of causation
24 approach -- which I do think is a very solid
25 approach for compensation. But the point is that

1 in order to be compensated under this program --
2 and remember, it's very -- very, very favorable
3 to the veterans because you're doing a 95 percent
4 confidence interval on your dosimetry. You're
5 doing a 50 percent PC with a 99 percent
6 confidence interval. I mean this is incredibly
7 favorable to the claimants. But most of the
8 veterans do not know and did not realize the
9 level of dose that it takes to be compensated.
10 It's a huge communication problem, and I hope
11 that you, as I said, can solve that as you go.

12 So if you were to go back and recalculate all
13 these doses, what difference would it make?
14 Probably not a lot. And I was talking to Tony
15 Principipi, the Secretary of the VA, about this.
16 And of course you might say that in one sense and
17 think well, you know, it's probably not worth it.
18 He is responsible for all of those veterans, and
19 he is listening to what you are saying and he's
20 said would it make a difference in some cases?
21 Those are my guys out there. And yes, it would.
22 And so he interprets this completely different
23 from what some of you might. And yes, it would
24 make a difference in some cases.

25 Okay. Other findings, and I've mentioned a

1 few of these and I'll kind of try to wrap some
2 things up and I wanted to read you a couple of
3 things. Communication with the vets, I think
4 what was lost in that, it's not so much the idea
5 of telling the veterans here's your dose, here's
6 what it means. But it's also the idea of
7 listening to what the veterans have to say. That
8 was not done. The veterans have a lot to -- had
9 a lot to tell us about what they went through.
10 And I want to read you a couple of things in a
11 few minutes, so communication very important.

12 Bioassay -- and Mike Schaeffer and his group
13 set out I think with something that was very,
14 very important, and if nothing else, it was huge
15 statement. And that was they tried to institute
16 a bioassay program looking at plutonium with
17 urinalysis, for which we have some very sensitive
18 methods, to see if there's some correlation and
19 to see if this method could be used to help
20 validate some of the dosimetry. I don't think
21 that they succeeded at this, and there are a lot
22 of reasons why and it's certainly not their fault
23 because I commend them for the statement of
24 trying to do this. But that's an example of an
25 area where we are making phenomenal progress in

1 science is the bioassay. And one technique in
2 particular -- and that is not my field and so
3 don't ask me a question about it, but I try to
4 read about it -- is the work in this fluorescent
5 in situ hybridization method which, from what I
6 understand, could be very amenable to what you're
7 doing. And I don't suggest this as a part of the
8 compensation program, let me make that clear. I
9 don't know how it fits in. I do suggest it as a
10 part of the science.

11 Where I challenged you at the beginning of
12 this talk to further the science, I think there
13 may be some opportunity for you to look at high
14 dose situations and to see whether the
15 biodosimetry could correlate, not to back up a
16 dose in any sense, but to -- it's something I
17 think you should think about. We did look hard
18 at the tooth enamel biodosimetry and we had some
19 people coming into all of our meetings really
20 pushing this method. But I don't think the level
21 of sensitivity of that approach is quite where we
22 need it to be. But anyway, I want to leave you
23 with that thought.

24 I said I would mention the internal dose
25 screen, and this is interesting because it was a

1 huge credibility problem that I think DTRA fought
2 for many years and just never could explain.
3 Early in the process there was a method developed
4 where -- and if you know something about the
5 deposition of fallout on soil, then if you know
6 how much was in soil you can make some
7 calculation of what a person might have inhaled
8 through some resuspension back calculations, so
9 what they got in the body so you can calculate an
10 internal organ dose, basically. And so they came
11 up with this method called the internal dose
12 screen -- and the idea is not a bad idea -- that
13 you could, by knowing what's on the soil, sort of
14 decide whether or not there's some potential for
15 internal dose. It's a screening process where
16 it's either you're in or you're out, and it's not
17 a bad idea.

18 But this got picked up by the veterans and of
19 course they're very critical and concerned that a
20 lot of people were being eliminated and internal
21 dose was not being calculated because of the use
22 of this internal dose screen. And so we tried to
23 tell the veterans after we looked into this well,
24 they really aren't using it. But you go to the
25 records and here it is, internal dose screen,

1 passed. Or internal dose screen, failed. And
2 you see why they were so confused.

3 And so we put -- and Dave Kocher wrote this
4 information that went into our report, trying to
5 explain to the veterans about the internal dose
6 screen. The bottom line is, it was not used.

7 So a message there is be careful with what
8 you say and be careful how you document
9 something, that it is going to be picked up by
10 these individuals. And if you're not using it,
11 make it clear why you're not using it.

12 Okay. And I think I'm getting through most
13 of this and I'm going to wrap it up in just a
14 moment, Paul. So let me just talk about three
15 issues and then I'll read you a few things from
16 the report that I think you'll find interesting.

17 The three things I'll mention now, and these
18 will be in the examples and that's why I wanted
19 to mention them -- benefit of the doubt, I've
20 mentioned that before. Let me read to you what
21 that means -- and I assume that you are
22 confronted with this, as well. Is that correct?
23 And -- and the law, and this is written in the
24 law -- (Reading) When after careful consideration
25 of all procurable and assembled data, a

1 reasonable doubt arises regarding service origin,
2 the degree of disability, or any other point,
3 such doubt will be resolved in favor of the
4 claimant.

5 Now I could read on, it's a fairly lengthy
6 paragraph that's legal language -- it's quite
7 legal language. But basically it means if you
8 don't know something and there's a chance that it
9 could have happened, then you have to assume in
10 favor of the claimant or in favor of the
11 assumption that makes the dose higher. Right?
12 Okay. So benefit of the doubt was very
13 important.

14 Second point is consistency, and I think this
15 is absolutely critical for you to keep in mind,
16 over time, that you are consistent, that you are
17 dealing with claimants in exactly the same way
18 with exactly the same fairness, with exactly the
19 same assumptions where you have a choice. And
20 that you're also being consistent between your
21 claimants so that you can say well, look, we've
22 done it exactly the same way with this person and
23 this person as we are doing it with you. And we
24 had some problems with consistency.

25 And third point is uncertainty. And I don't

1 want to get on -- get off track when I talk about
2 this, and I'm going to be very blunt with you,
3 and some of my friends will not like what I'm
4 about to say. But I'm concerned that we're
5 getting too far ahead of ourselves with
6 uncertainty. I think it's a great tangent to our
7 science. I think it's wonderful that we have the
8 calculating tools that we have today that ten
9 years ago you'd have to have a mainframe computer
10 to do. But I also worry sometime that we're
11 misleading people when we suggest that
12 uncertainty is accounting for all of our lack of
13 knowledge when it's a part of the lack of
14 knowledge. I don't know how to make that any
15 more clear. But I urge you to be careful here.
16 And there may be some situations -- and it might
17 simplify your work, Dick and Larry, in
18 particular, when you think hard about going
19 through a mathematical calculation or a Monte
20 Carlo analysis when you can use a single number
21 that might take some upper bound into account.
22 And I will be honest with you that over the last
23 couple of years as a scientist, I'm more and more
24 going back to the simple roots where I started
25 from, where deterministic calculations are not

1 always bad. And by making a deterministic
2 calculation doesn't necessarily mean that we're
3 perceived to be ignoring all of this variability.
4 I'm not trying to suggest to you in any way that
5 you don't do Monte Carlo calculations. I just
6 want you to be careful about what you can defend
7 and what you can't defend as scientists.

8 I'm on Committee IV of ICRP, and right now
9 one of the things that we're looking at -- and we
10 have a committee that probably -- that is trying
11 to take this on. ICRP has never clearly defined
12 -- and ICRP is the International Commission of
13 Radiological Protection, if you don't know, I'm
14 sorry -- and it makes recommendations to the
15 world about how we protect people in the
16 compliance area -- primarily in the compliance
17 area. We want to protect people. But for years
18 ICRP has gotten better and better at coming up
19 with dose conversion factors for the fetus, for
20 the six-month-old, for the one-year-old, for the
21 ten-year-old -- I mean we have really gotten to
22 where we can refine -- or I think we've refined
23 dose to all these individual age groups and
24 different sexes and so forth.

25 But as we look back on it in ICRP, we're

1 concerned that these different categories are
2 being misused -- for the compliance purpose, now;
3 for the compliance purpose. And so one of the
4 things that we're looking at is how can you put
5 together and age-weighted dose coefficient that
6 takes into account an entire lifetime of an
7 individual, because really that's what limits are
8 based on is lifetime exposure. So that's
9 something that's being done.

10 And another thing that's being done is that
11 ICRP wants to make it very clear what is assumed
12 to be uncertain and what is not, in the realm of
13 radiation protection. A little different from
14 what you're doing now. But dose coefficients in
15 the ICRP system are assumed not to be -- are
16 assumed to be -- are assumed not to be uncertain.
17 I want to be sure and say that right. In other
18 words, they're fixed, for radiation protection
19 purposes. I'm going to tell you again, that's
20 not the way you're using them, the way I
21 understand it.

22 On the other hand, my point is, just be
23 thinking, if there are some things in your
24 calculation that you really just don't have a
25 clue, and by coming up with a distribution of

1 possibilities you're really stretching your
2 imagination, then why not use a fixed value and
3 just tell people that's the way it is.

4 Okay, I'm off that soap box. All right?

5 So let me just read you a couple of things
6 and then finish up here. I'm okay on time, just
7 a few more minutes? Okay.

8 I think just a few of these cases. We found
9 the records just absolutely fascinating, and I
10 think, as much as anything, what the veterans
11 were saying. It is amazing the effort that some
12 veterans went to to try to explain to these
13 dosimetrists what happened to them.

14 Let's see -- I'll also tell you that this
15 report -- I wanted it to be readable and I wanted
16 it to be interesting, and it's got photos all the
17 way through it, so you'll enjoy looking at some
18 of the photographs. You will be absolutely
19 amazed at some of these photographs where people
20 are leaning into this tank that was just a few
21 hundred yards from ground zero very soon after
22 the shot. The conditions -- the dust and so
23 forth -- under which they worked was amazing to
24 me, that's for sure.

25 Okay, here's a case, this is case number 22,

1 and I'm just going to read this. It says
2 (Reading) The participant claimed that he was
3 present at Operation Ivy. His service records
4 have been damaged and his claim that he
5 participated in Ivy could not be verified. He
6 was not given the benefit of the doubt in
7 evaluating his claim for a non-presumptive
8 disease and no dose was calculated for
9 participation in Ivy, nor was the estimated upper
10 bound of his assigned dose from his participation
11 in other tests adjusted to reflect his possibly
12 participation in Ivy.

13 But he was never contacted to investigate
14 this matter further, so now there's a case where
15 the veteran says I was there, the records might
16 indicate you can't prove he was there, so what do
17 you do? Benefit of the doubt.

18 Case 53, this case provides a good example of
19 inconsistent -- remember consistency --
20 inconsistent application of assumptions used in
21 estimating the external dose in the upper bound
22 from boarding target ships at Operation
23 Crossroads. The dose memorandum states that the
24 veteran was given the benefit of the doubt by
25 presuming that he participated in two-thirds of

1 the target ship boardings by his unit. However,
2 the calculations in the case are based on only
3 one-third of the boardings. In other cases
4 involving target ship boarding -- and we give the
5 number of some of the other cases -- veterans
6 were usually given the benefit of the doubt by
7 assuming that they participated in all boardings.

8 Consistency, remember that.

9 I think I'll just do one more and let me just
10 tell you -- tell you this story. It's kind of --
11 quite amazing, because the very first time we
12 went to DTRA to look at the records, we were sort
13 of given free rein of pulling out the files and
14 picking a file and then if we wanted to take one
15 back with us, they were going to take any
16 reference to name off, redact it. I happened to
17 go into a file -- and totally at random I pulled
18 this record out. It turned out to be possibly
19 the most interesting in the whole study. But
20 there was a veteran who was an aircraft crew
21 mechanic and he filed for a dose claim, and his
22 story was this; that there was a test in the
23 Pacific and these sample planes, as you know,
24 flew through the cloud. And the planes -- when
25 they did this, they were collecting samples, but

1 they also became quite contaminated, just the
2 fuselage of the plane itself became very
3 contaminated. Two of these planes were flying
4 together. One of the planes had a serious
5 mechanical problem and went down in the ocean.
6 The other plane, because he was trying to stay
7 with his fellow pilot, had to make an emergency
8 landing on Kwajalein, I think it was, the island.
9 And when he came down, he really hit the runway
10 hard and it blew the tires on the plane. So he
11 was stuck there. He was also about out of fuel.
12 And so this mechanic was flown in immediately to
13 repair the aircraft and to refuel the aircraft.
14 And so he came in -- now think about this. This
15 is very, very soon after the plane had been
16 flying through the cloud. He came in and --
17 we've got a picture of the aircraft, but he gets
18 down, he changes the tires. And the veteran said
19 he was there about four hours.

20 The analyst who did the dose reconstruction
21 said it took about one hour. But that's not the
22 key point. The key point is that in the initial
23 dose reconstruction he was assigned a dose of
24 zero. And the veteran just didn't buy this, and
25 he -- he also had pointed out it took more than

1 four hours to get decontaminated when he finally
2 got back.

3 So he complained and they reconstructed the
4 dose and the second dose reconstruction, what
5 they did was to start working with the -- an
6 exposure reading four inches from the pylon on
7 the aircraft, but it was four days later. Okay?
8 Which theoretically that's not a bad idea because
9 if you can just extrapolate back in time, you
10 should be able to come up with a reasonable
11 estimate of what the reading was on the aircraft.
12 Unfortunately they didn't take into account that
13 this plane was likely scrubbed -- washed. Okay?
14 And we know that they were and we've seen the
15 data. And so the second dose that they came up
16 with was -- was not much better. I think it was
17 .8 rem.

18 Anyway, when we looked at this record, we
19 really took issue with almost every assumption
20 that they made. But I think that's a good case
21 where the veteran persisted and persisted and
22 persisted and finally the dose reconstruction was
23 raised enough -- I don't know whether or not this
24 veteran received compensation, but it's an
25 incredible story and the level of detail that you

1 have to go into in these dose reconstructions, I
2 think that's just one of the best examples I've
3 ever seen.

4 I think I'll stop and if you want, we can
5 just chat a bit, Paul, or if there are any
6 questions. I am going to stick around for about
7 an hour before I have to leave.

8 I want to really commend you all for what
9 you're doing. There is no amount of money that's
10 going to pay you -- no amount of government
11 money, anyway -- that's going to pay you
12 appropriately for the time that you're putting in
13 to do this.

14 On the other hand -- wow, what I have learned
15 over the years from some of the work that I've
16 done is the importance that there is some kind of
17 oversight that represents the entire spectrum of
18 views, non-scientists and scientists, because
19 ladies and gentlemen, we don't have all the
20 answers. I was very intrigued by your -- Dick's
21 talk this morning, by the questions that you
22 asked him and how you challenged him on
23 credibility, on conflict of interest, on the
24 details of what they're doing. Stick to it.
25 Thank you.

1 **DR. ZIEMER:** Thank you very much, John, for a
2 very challenging discussion. Let's take a few
3 minutes for some questions at this point, then
4 we're going to take a break. We'll start with
5 Roy here.

6 **DR. DEHART:** Thank you very much. It helps
7 place us in context, and we appreciate that. You
8 mentioned consistency, and one of the battles I
9 fight with myself is a legislative ruling which
10 indicates inconsistency, and this is the Special
11 Cohort area. And we have a Special Cohort of
12 atomic workers who has a listing of presumption
13 with cancer and there is no dose reconstruction.
14 If they have the cancer, they're awarded a
15 disability or an impairment or a financial award.
16 And everybody else who may have worked in similar
17 areas, these -- what I'm talking about is the
18 gaseous diffusion plants -- the other areas,
19 everybody else is having to go through a dose
20 reconstruction. And there is repeatedly in the
21 comments from the public this issue of
22 inconsistency in the management of those cases.
23 And I just wondered how you would deal with
24 something like that.

25 **DR. TILL:** That's tough. That's tough. What

1 has generally happened over time, if you look at
2 the history I think with the veterans, is that
3 when we make a decision it's generally been in
4 favor of the claimant. Is that good? I mean
5 we've kept adding cancers to the presumptive
6 list. Okay? I think we can go too far with
7 that. I think -- I guess my answer is I think
8 that may be a -- I don't know why the decision
9 was made differently and I don't understand the
10 legal aspects of this, okay?, but you have -- but
11 I guess my answer is, you know, maybe that's a
12 case for inconsistency. I don't know that you
13 now say well, because you're doing this to a
14 smaller group for some reason -- and you've got
15 to look at why -- do you therefore go back and
16 bring everybody else into that category. That's
17 tough to say.

18 I mean remember what you're doing, without
19 that special case, has a good foundation. So --
20 so is that a reason to change your method? You
21 really put me on the spot with that and I guess
22 my answer would be stick with your plan. There
23 are going to be cases for inconsistency. And I'm
24 -- I can't deal with the law. Okay? You're
25 going to let those guys deal with the law. I'm

1 talking about consistency in the science, in our
2 methods and in our assumptions. So you kind of
3 threw me a curve on that one, but that would be
4 my answer. Just recognize it exists and move
5 forward. If Congress wants to change it, let
6 them change it -- or whoever makes the law.

7 **DR. ZIEMER:** Gen?

8 **DR. ROESSLER:** John, you mentioned
9 communication a number of times in your talk and
10 you also said that -- of the veteran study --
11 there was a lousy job. We've learned a lot over
12 time and I think you've learned a lot in the
13 projects you've been involved with. And I think
14 you know a little bit about what we're doing. We
15 have the open meetings. We have -- NIOSH has a
16 wonderful web site. I'm not sure people use web
17 sites -- I'm sure they don't, and so that might
18 be a problem. But what would you recommend to
19 our group that we could do better in the way of
20 communication?

21 **DR. TILL:** Well, certainly when we were
22 working on the veteran work -- again, Mike and
23 DTRA, I'm not trying to be critical of you guys -
24 - but I think that's an area that we really fell
25 down in. We didn't do that much with the

1 Academy. We opened our meetings, which is a huge
2 step for the Academy in a lot of cases, but we
3 also went to the NAAV meeting -- we went to one
4 NAAV meeting. We invited the veterans to come in
5 and talk to us. So to answer your question, Gen,
6 I would be very aggressive about it. I would
7 look for new ways -- what you want to do is
8 establish a track record that says you've done
9 this. Whether it's successful or not, you tried.
10 Okay?

11 I'm assuming that you have workers come and
12 talk to you, and I would try to do that
13 regularly. Okay? Just so that it's on your
14 agenda a lot. Okay? I would make an effort --
15 and I know you meet in a lot of different places.
16 Make sure that you have a record of trying to go
17 to the -- those exposed, as opposed to okay,
18 we're going to meet in your city; if you want to
19 come, come.

20 And I think, Gen, this is something I'm
21 learning more and more about with communication,
22 and I had always had this approach well, I'm a
23 scientist and I don't have to do it. That's how
24 I started. And then I shifted into the mode of
25 well, I'm a scientist. You come in and you can

1 tell me what you think is wrong or how to do it
2 better. That was my second phase of life. My
3 third phase of life, which is now, is I'm going
4 to the people and I'm making the effort to go to
5 the people because a lot of people don't want to
6 come to you. And that way you've got the track
7 record of having done it. But I think you'll
8 also be amazed at some of the things you'll hear
9 and the concerns you'll get.

10 So the idea is just be very aggressive about
11 this. Don't think it's sufficient to sit here as
12 a committee, open your doors and say come and
13 talk to us, we've got a public comment period.
14 Try to do more.

15 Mary Lou Blasik*, who taught us a lot, Gen, I
16 think would have been happy to hear me say that,
17 but ten years ago I probably wouldn't have. Does
18 that help? Does that help or is that not
19 specific enough?

20 **DR. ROESSLER:** I know what you're getting at
21 and I can think of specific things -- things that
22 I don't think we're doing, but I wouldn't mind if
23 you mentioned some specific things. I think that
24 would help.

25 **DR. TILL:** Okay. Well, I assume you have a

1 newsletter -- do you? No? That's a good idea,
2 and you put things in a newsletter like
3 probability of causations, here's what it's going
4 to take you, here's what we know about the
5 science. Okay? A newsletter, I think, is a very
6 good thing.

7 The web -- does the web do that, Larry, or
8 not?

9 **MR. ELLIOTT:** It talks about it.

10 **DR. TILL:** I've seen your web site. Okay.

11 **MR. ELLIOTT:** We have brochures that we send
12 with our letters to the claimants that speak to
13 probability of causation and dose reconstruction.

14 **DR. TILL:** Okay.

15 **MR. ELLIOTT:** The web site also has topic
16 pages on both of those areas.

17 **DR. TILL:** Okay. Well, I know that -- I know
18 we're in the electronic age, but believe me, most
19 people out there and most people who are filing
20 claims with you don't look at the web, and they
21 won't. They don't know how. So a newsletter's
22 not a bad idea. And at some frequency where you
23 really put substantive stuff in there that tells
24 you what you're learning. Put out -- who -- how
25 many people are getting awarded claims, what's

1 the percentage, so people understand.

2 And I still think when you go into a city,
3 don't just have your meeting. Tell people you're
4 willing to sit with them one-on-one, small
5 groups, and -- you know, let's get together.
6 We'll get together for dinner, whatever, and talk
7 about what we're doing. You will make more
8 ground with a small group like that -- if you
9 break up, in particular -- than you ever will
10 asking people to come in and talk to you.

11 And what I'll do, Gen, if I think of more
12 specifics, I'll tell you. But the web, too, is
13 very important and this information going on the
14 web, like a newsletter -- hard copy and web -- is
15 good.

16 **DR. ZIEMER:** Mark?

17 **MR. GRIFFON:** Yeah, John, I had a couple of
18 questions. One on the -- you mentioned
19 participant statements, and I -- looking through
20 the report quickly, I noticed that you had an
21 opportunity in a lot of your reviews -- maybe not
22 all of them, but the question is, were these
23 participant statements part of the file or did
24 your -- your board, in doing the review, elicit
25 participant statements or how did those come to

1 be in the file? That's the first question.

2 **DR. TILL:** Okay. We found far few statements
3 -- fewer statements in the file than we would
4 like to have seen. We think that was a serious
5 mistake not to go to the veterans. There were
6 forms, especially early on, where the veteran
7 could check off and answer questions. The best
8 information was information in the format of a
9 letter. You'll see some in this report. And
10 they will absolutely amaze you at the detail
11 these people could remember. I mean the detail.
12 The best ones were probably in the files that the
13 veterans gave us, 'cause we just didn't discover
14 them in -- in our random search. Okay? But they
15 were probably there if you went to the file. So
16 it wasn't that we went out and asked the veterans
17 for the information. It was what we were looking
18 for in the record, and there was not enough of
19 it. And in a lot of cases, we felt the letters
20 were ignored -- some cases. Not a lot, some.

21 **MR. GRIFFON:** Right. And just the other --
22 the other question was you mentioned these four
23 broad criteria, which we've sort of adopted in
24 some form or fashion. I wondered, for your
25 committee, whether you developed procedures on

1 how you were going to evaluate against those
2 criteria for consistency on your board. And in
3 terms of -- I guess I'm looking at the nuts and
4 bolts of this since our working group is
5 constructing some of that and the approach you
6 took to how to evaluate against whether the dose
7 reconstruction was accurate. And if those
8 procedures were developed, are they available to
9 us?

10 **DR. TILL:** No, it's very interesting. The
11 answer to that is that when we started the case
12 reviews, when we finally got our first set of
13 cases to look at, we did have a list of criteria
14 that we were looking for. And I can't remember
15 exactly, maybe seven, eight, ten specific things
16 that -- I think we even formed a check sheet, you
17 know, and gave grades. I think this is correct.

18 We gave up on it, because it was so
19 difficult, the cases were so different, that we
20 found that those criteria we thought were so
21 wonderful, we never could apply to all the cases.

22 Now I think -- I think, Mark, in the back of
23 our heads that we were keeping those things in
24 mind. But the answer is we did not have some
25 specific list of criteria that every time we got

1 together we said let's go through these.

2 On the other hand, I think what happened,
3 what evolved from this, is that as we went
4 through, you know, 50 or 60 cases, we were
5 evolving into several key issues. And I remember
6 a meeting -- you know, I mean I think that's just
7 -- this is the way any committee would work. You
8 know, after you've looked at a lot of specific
9 situations, you kind of involve to what you think
10 are the key points, and then that's what came out
11 of it. Does that answer your question? So I
12 don't think what we did will help you.

13 **UNIDENTIFIED:** (Inaudible)

14 **DR. TILL:** Okay, sorry.

15 **DR. ZIEMER:** Wanda, you have a question?

16 **MS. MUNN:** First a comment rather than a
17 question. Thank you so much, Dr. Till. I have
18 not had an opportunity to -- like many of our
19 claimants -- view what's on the web with respect
20 to the Academy's forthcoming publication, so I'm
21 looking forward to it eagerly.

22 Particularly want to thank you with regard to
23 your comments relative to staying flexible in
24 terms of changing science. I see a dilemma
25 there, however, and the dilemma is when do you

1 decide to revisit this if the science changes and
2 when not? I don't know whether your committee
3 made any decisions in that regard or not. If
4 they have, it would be beneficial I think for us
5 to be aware of what they are.

6 And there's a second item that I wonder about
7 with regard to your experience. Clearly from the
8 claims that we are seeing now, we have a larger
9 number of claims that are being brought to us by
10 families, by heirs, rather than by the
11 individuals themselves. Therefore, first-hand
12 information is not as easily available to us as
13 perhaps it may have been in many of your cases.
14 The claimants in those majority of cases express
15 great frustration with the fact that they know
16 very little about their loved ones' actual work
17 place and what transpired, what their real
18 experiences were. So we have a slightly
19 different struggle in that regard in an attempt
20 to try to reach a greater level of certainty
21 regarding what might have been missed in that
22 process.

23 I don't expect you to provide me any answer
24 to that, but I really would like to hear what
25 your experience was with regard to keeping up on

1 the science.

2 **DR. TILL:** With regard to the science, I
3 don't think we recommended what should be done.
4 We just recommended that this -- some policy be
5 established to update -- or not update, but at
6 least to recognize that the science is changing.
7 Because I think there were some changes in the
8 science, but it was sort of haphazard. I mean it
9 wasn't a deliberateness. All right? And there
10 also was no clear policy on if we change the
11 science, what does it do to the previous
12 calculations. And I think you need to address
13 that. So I think you have to make your own
14 decision about changes in the science. I think -
15 - fortunately, hopefully -- what you are
16 undertaking is a shorter term deal, because
17 you're going after this pretty aggressively. You
18 want to respond to these people quickly.

19 So I'm not sure how much the science is going
20 to change in the five years or whatever time
21 you're going to be here. But what if it does?
22 Okay? Maybe you don't want to change the
23 science. Maybe you want to fix it in time so
24 that everybody's treated the same. This is a
25 policy decision I think you have to make. And

1 then if you change it, do you go back and make --
2 and recalculate those doses for awards? I think
3 my own personal opinion is that you wouldn't go
4 back and take anybody's claim away, but you might
5 go back and recalculate doses because it may
6 throw some people into a higher dose category and
7 entitle them to something. That is something we
8 pointed out in the report that somehow VA and
9 DTRA have to consider.

10 So did I answer that okay for you?

11 **MS. MUNN:** Consequently, it would behoove us
12 to be very cautious in the way we maintain our
13 database so that we --

14 **DR. TILL:** Yeah.

15 **MS. MUNN:** -- can pull only those cases that
16 are relevant.

17 **DR. TILL:** Oh, but I think it can be done.
18 There's no question about it. I'm sure you're
19 keeping a database that will allow you to do
20 this. I am sure you can do this. I think it's
21 strictly a policy of this Committee, strictly.

22 All right. The other question, though, there
23 is an answer to the other question, I think,
24 because we did have situation where widows were
25 filing claims for veterans. I don't want to say

1 whether it was done well or not done well, but
2 there is a way to address that and you go to the
3 buddy system. You find some people who knew this
4 individual and who had similar work style of this
5 individual, and I think that's a perfectly
6 legitimate, defensible way of coming up with a
7 dose estimate. So it can be done. Yeah, okay.

8 **DR. ZIEMER:** Mike, let's make this the last
9 question. We do need to provide a comfort break
10 for people and there will be opportunities -- no,
11 you give your question, right. Right.

12 **MR. GIBSON:** Thanks for being here today.
13 You mentioned consistency as being one of the
14 important factors, and just to follow up on Dr.
15 DeHart's question, let's just say hypothetically
16 a point in time came where people unknowingly got
17 exposed to radiation and a time subsequent to
18 that a law was passed. That's why they were put
19 in the Special Exposure Cohort.

20 Now as we go on down the path, if we find a
21 similar set of circumstances for another group of
22 workers that fits all the criteria that put those
23 workers at the gaseous diffusion plants in a
24 Special Exposure Cohort, in your opinion, would
25 that be consistent then for us to look at their

1 petition and consider putting them in the Special
2 Cohort?

3 **DR. TILL:** You guys are really stretching my
4 knowledge here today. If I were a member of the
5 Committee, I would say that's fair and that's a
6 part of my job that I would at least probe that.
7 Okay? Because you're an advocate for -- some are
8 you are advocate for the claimants and some of
9 you are advocate for science or whatever. You're
10 all here with a responsible position, and I think
11 that's a part of your charge, yes. And then it's
12 up to whether or not the law gets changed to
13 invoke it, I guess. But yeah, I think that's why
14 you're sitting here.

15 That's not what I meant by inconsistency, at
16 all. I really was talking about science and
17 methods and doing the math the same way and
18 giving everybody the same benefit of the doubt.
19 This is getting in -- more into the law.

20 **MR. GIBSON:** Then -- that's what I was trying
21 to do is leaving the legalese out of it and just
22 say -- let's just say hypothetically, if one
23 group meets the same criteria that the group met
24 that was included when the law was passed, then
25 when they bring that proof forward, it would be

1 consistent --

2 **DR. TILL:** That's why you're here.

3 **MR. GIBSON:** -- it would be consistent --

4 **DR. TILL:** I think that's why you're here is
5 to look out for those things.

6 **MR. GIBSON:** Thank you.

7 **DR. TILL:** Paul, thank you very much.

8 **DR. ZIEMER:** Thank you, John --

9 **DR. TILL:** It's very good to see you again.

10 **DR. ZIEMER:** -- for being with us today and
11 if you're willing to stick around a little --

12 **DR. TILL:** Yeah.

13 **DR. ZIEMER:** -- others may want to chat with
14 you individually during the break. Thank you.

15 We'll take a 15-minute break.

16 (Whereupon, a recess was taken.)

17 **DR. ZIEMER:** Before our next agenda item,
18 just a brief announcement. Larry?

19 **MR. ELLIOTT:** Just so you all know that at
20 your desk you'll -- or at your place here at the
21 table, you'll find the physician nomination
22 criteria that we have used in the appointment of
23 the 100-plus physicians for DOE. If you have any
24 questions about that or comments or concerns,
25 please let me or Dave Sundin know. We'll react

1 to those. Thanks.

2 **DR. ZIEMER:** Okay, thank you, Larry. Then
3 our next agenda item is Jim Neton's report on the
4 status of the technical basis documents. Jim.

5 **STATUS OF TECHNICAL BASIS DOCUMENT/SITE**
6 **PROFILE DEVELOPMENT**

7 **DR. NETON:** Okay. Thank you, Dr. Ziemer.
8 This is a companion piece that goes with Dr.
9 Toohey's talk this morning and will tend to
10 describe to you some of the more inner details
11 and workings of how these technical basis
12 documents are put together. Since some of the
13 stuff was gone over briefly by Dr. Toohey this
14 morning, I probably won't take the full hour that
15 I was allotted, which you're probably glad about
16 since it's nearing the lunch hour, so I should be
17 able to probably get through this fairly quickly.

18 We recognized early on that we needed a
19 number of these site profiles. In fact, we need
20 essentially one for every site, at least the
21 major DOE sites, to be able to do our job of dose
22 reconstruction. These serve sort of as a road
23 map, I like to call them, as to how you do a dose
24 reconstruction for a particular site. And by
25 their very nature, they're limited in scope.

1 They're not epidemiologic reviews. They're not
2 how-to guides for the dose reconstructor or
3 detailed responses to how you treat it, but
4 really it's just a summary used by the dose
5 reconstructor to provide him site-specific
6 information.

7 For example, if a claimant has worked in
8 1950, 1955 time frame, one should be able to find
9 some detail in that road map as to what detection
10 limits were for the badges that were worn, the
11 number of times it was exchanged on a -- how
12 frequently the badge was exchanged, that type of
13 information. It helps to minimize interpretation
14 of data because I think as you saw this morning,
15 we have -- I was surprised actually the number's
16 up to 300 people working on this project. These
17 dose reconstructors, by design, are distributed
18 around the country. It's the only way we could
19 get a critical mass of people sufficient to
20 complete these in a timely manner. So many of
21 them are working independently, without benefit
22 of interchange -- you know, sort of office
23 chatter. So it helps to minimize interpretation
24 of the data to ensure what we heard earlier is
25 consistency among these dose reconstructions.

1 Again, it's used basically as a handbook.

2 And these are dynamic documents. Rev. zero,
3 when it comes out, is not the end of it. As
4 information is obtained further through either
5 site searches or from claimants, these things
6 will be amended as we go.

7 Okay, a little bit about the definition. I
8 know there's confusion along the -- the audience
9 and possibly the Board as to what we mean by a
10 site profile. It really is a compilation of
11 individual technical basis documents which covers
12 the five bullet items here -- facility/processes,
13 environmental dose, external dose, internal dose,
14 diagnostic X-ray information. So it's a series
15 of chapters that describe in some detail each of
16 these type of areas that are needed to do a dose
17 reconstruction.

18 Each section is intended to be a stand-alone
19 document, so we can develop these as we go. The
20 idea was that we wouldn't have to wait for the
21 entire site profile to be done to start moving
22 some claims forward. We're trying to -- always
23 looking toward optimizing the process and
24 maximizing our efficiency. So for example, if we
25 had a worker who was only -- who had only worked

1 exterior to the plant and had been exposed to
2 environmental dose, if the environmental dose
3 reports were available and we could reconstruct
4 their exposure, then we could do so without the
5 benefit of having to, you know, flesh out all the
6 internal dosimetry and external dosimetry
7 information.

8 I think we've talked about this enough at a
9 number of Board meetings, but there is a certain
10 hierarchy of data that are used to do these dose
11 reconstructions. Starting at the very top with
12 personal dosimetry and moving all the way down
13 through the bottom to source term and radiation
14 control limits, I think this is well-known by the
15 Board. We don't really need to go over these.
16 But this is just up there to illustrate that the
17 site profiles tend to try to be true to that
18 concept so that they do follow, you know, what
19 was intended when the rule was written.

20 Okay, a little bit about timing of these
21 documents. This is a generic chart -- by the
22 way, I would like to acknowledge the help from
23 our contractor, ORAU, Dick Toohy and Judson
24 Kenoyer for helping put some of these slides
25 together. But this is a generic time line for

1 how long it takes to get a site profile together.
2 As you can see, it ranges out to about 16 weeks.
3 Some can be shorter, some can be longer, really
4 depends on the site. But in general, there's
5 some steps in here -- to review the available
6 data, and then to see if you have an update or
7 request additional information. That may require
8 going back to the site, talking to site contacts,
9 conference calls, any -- any way that we can get
10 information. In fact, sometimes looking through
11 the claimant files we've actually found some
12 leads of what the claimants have submitted with
13 their files to flesh out these dose -- these site
14 profiles a little better.

15 So given that these things can take a while,
16 up to three, four months to complete, the
17 decision was made a while ago that we would do
18 these in parallel. And as you heard Dr. Toohey
19 talk about earlier, there are 12 or 13 individual
20 teams out there right now working on these things
21 so that they can complete it and move the dose
22 reconstructions for those sites forward.

23 A little bit about the process. It's a
24 fairly formalized process to get these things out
25 the door. These are issued as controlled

1 documents, but what you see on the left-hand side
2 is the informal process. And what I mentioned a
3 little bit this morning during the discussion of
4 Dr. Toohey's presentation is we actually have a
5 NIOSH health physicist assigned on the dose re--
6 on the technical basis document or site profile
7 team, so that all along there is sort of this
8 informal review process going on of the document
9 so there are no surprises. You know, we didn't
10 feel it was worth waiting three months, ORAU
11 would develop this document and we'd say no, you
12 know, that just doesn't really seem right to us.
13 So in this informal process, NIOSH is involved in
14 resolving comments before it ever comes over here
15 for the official review.

16 These things are officially commented on,
17 once it comes over, by us. We provide written
18 comments. ORAU is required to respond. We have
19 what we call critical review comments and non-
20 critical review comments. If it's critical
21 review, it must be addressed. So in that review
22 process it's an iterative process that occurs
23 where comments are considered, reviewed, and we
24 come to some consensus opinion as to how we're
25 going to proceed.

1 Once the document is completed with a NIOSH
2 official review, it goes into our document
3 control process. Well, this is an ORAU document.
4 It goes into their document control process, but
5 it is signed both by NIOSH, that would be Dr.
6 Toohey and myself as the authorizer for the
7 document to be released for use. It has a
8 revision date and a revision number, and we will
9 always keep track of the revs. as we go so we
10 know which dose reconstructions were done with
11 which revs. of the technical basis documents.

12 Okay. What kind of resources do we use to
13 put these things together? And it comes from
14 just about any source, any source that we can get
15 reliable -- probably the best resources that we
16 have are some of these site technical basis
17 documents that the DOE sites themselves put
18 together. As DOE rad. control programs matured
19 in I guess probably the early to mid-1980s,
20 technical basis documents were required for the
21 external/internal programs. And these things not
22 only tend to document what's currently being
23 done, but also usually have some sort of
24 historical discussion at the beginning, and it's
25 a good starting point for us to branch out and to

1 obtain additional information.

2 Also useful are safety analysis reports that
3 were completed for certain projects 'cause those
4 tend to be all-encompassing, talking about
5 process descriptions, potential radiation
6 exposure environments, that type of information.

7 Work place environmental reports are very
8 useful. It's somewhat different than the site
9 environmental reports where you're talking about
10 fence-line dose. We really are not interested in
11 the dose at the fence-line. We're of course
12 interested in the dose to the workers who were
13 either in buildings or around buildings. So
14 where we can find those reports, they're used.

15 And facility data, which would be the area
16 monitoring results -- air samples, surface
17 smears, survey swipes, those type of pieces of
18 data, if we can obtain them -- internal memos,
19 correspondence sometimes are useful. Any
20 publication, particularly peer review
21 publications that may be available, we obtain.
22 Most recently there's a very good publication
23 regarding the solubility class of materials at
24 the Y-12 facility that we've tried to use and
25 incorporate into some of our documents. Previous

1 dose reconstruction reports, whether they were
2 done hand-crafted basis by the supplemental team
3 or dose reconstructions that have been done --
4 for instance, at the Mound site -- we would use
5 as a starting point. We wouldn't use them
6 necessarily, but we would evaluate them to see
7 how applicable they may be to our situation.

8 And I mentioned previously, sometimes
9 information submitted to NIOSH by claimants in
10 particular has been beneficial. That was the
11 case for the Bethlehem Steel technical basis
12 document. A claimant had some pretty rich sets
13 of data in there that led us to other sets of
14 data and helped us develop that document.

15 And there's other things here, other site
16 reports, web sites, conference calls, contacts
17 and visits. So anywhere we can get the
18 information is basically it.

19 Okay. The parameters of interest, as we
20 discussed earlier, medical X-ray dose is one of
21 the sections. Occupational dose for unmonitored
22 workers, which is a somewhat unique situation. I
23 mean if you've monitored, then we can flesh out
24 your dose a little bit by looking at the missed
25 dose for the monitoring program itself. But if

1 you're unmonitored, it's not that straightforward
2 to figuring out what the potential dose could
3 have been, and we'll talk about a little bit of
4 these as we go. Occupational internal dose for
5 monitored workers, and then occupational external
6 dose for monitored individuals. So these are the
7 areas that the site profile attempts to address.

8 Medical X-ray dose is addressed by year. Of
9 course the X-ray monitoring technology has
10 changed dramatically since the early '50s, so we
11 need to know what year the X-ray was taken and we
12 can try to determine what the dose may have been
13 by the type of the machine or the technique used
14 at the time. Dr. Toohey mentioned earlier about
15 this photofluorographic technique that was used
16 in the '50s. That's probably the extreme
17 example, but those doses can be very large. In
18 some cases we've noticed at the Savannah River
19 Site that the collimation* was wide open so that
20 all of the organs or most of the organs may have
21 been exposed versus just the narrow field of view
22 of the lung, which was the subject of interest of
23 the X-ray. So all these things are taken into
24 account and attempted to -- we attempt to address
25 them in the site profile.

1 By organ, of course, if it's a columnated*
2 field and one's taking an AP chest X-ray, then
3 the dose to the bladder is going to be somewhat
4 less than the dose directly delivered to the
5 lung, or typically the entrance skin exposure,
6 which is usually what's quoted for an X-ray
7 machine. And there is some attempt, to the
8 extent possible, to address uncertainties.

9 Okay. Occupational dose for unmonitored
10 workers, we'll first talk about internal dose.
11 If a person was not monitored for internal
12 exposure -- you have no record of any bioassay
13 sample, no whole-body count, no urine sample, no
14 breath analysis, anything of that nature -- it
15 becomes a little bit tricky to figure out what
16 the upper limit of the person's exposure could
17 have been. So we attempt to address that by
18 looking at the inhalation based on air
19 monitoring. If the air monitoring data are
20 readily available -- that is, they're not in the
21 plants in 100 boxes distributed about there --
22 about the plant, you know, they're fairly
23 consolidated -- I think the situation exists for
24 the Fernald site; we have some pretty good air
25 monitoring data -- that would be described in the

1 technical basis document and how that could be
2 used to assign some bracketing exposures for a
3 worker who was unmonitored for internal exposure.

4 If the information's not available -- or
5 readily available, and by readily I mean it
6 wouldn't be a million-dollar research project to
7 go retrieve these records and code them and that
8 sort of thing, we would have to default to the
9 source term analysis, which would be what type of
10 material was used at the site, what was the
11 process -- grinding, welding, that sort of --
12 were performed on the -- at that facility. And
13 in certain circumstances, even if you know the
14 source term, we would use claimant-favorable
15 assumptions. For example, if we didn't know --
16 if the person -- if the source term indicated
17 that there was a machine that would convert
18 billets into rods or something of that sort of
19 thing, and we didn't know where the person worked
20 relative to that instrument or machine, we would
21 use claimant-favorable assumptions and assume
22 they spent the majority of their time working
23 near that machine.

24 Internal exposure for outside facilities, if
25 a person is not in the facility where the

1 equipment is being used to generate airborne
2 radioactivity, then we have a little bit more of
3 a problem. We have to know something about the
4 site ambient radionuclide activities, and that
5 takes a little bit of work. But as we talk about
6 -- I'll talk about shortly in the environmental
7 dose reconstruction area, there's some things we
8 can do there, and I think I have an example in
9 the Savannah River technical basis document.

10 Occupational dose for unmonitored workers in
11 the external area is also addressed in the
12 document. If the exposure probability is low, we
13 can use some sort of reasonable background dose -
14 - maximum background dose that we can determine,
15 whether it's based on area that was out there or
16 if we had examples of what coworkers -- they
17 wouldn't necessarily be representative coworkers,
18 but maximum coworkers, people who were probably
19 exposed to higher levels, we could use that.

20 If the exposure probability is high, we would
21 use coworker data or claimant-favorable
22 assumptions. Again if -- an example of a
23 security guard who was not monitored who maybe
24 took -- you know, made a round through the
25 facility. If we knew what the maximum dose was

1 to any worker in each of the facilities that the
2 security guard visited, and we knew the amount of
3 time it would take to do the rounds through his
4 run, we could come up with some bracketing doses
5 for that particular person in the external area.

6 The document also, though, addresses the
7 release of any noble gases -- sometimes
8 submersion in a cloud of noble gas from an
9 external perspective, whether it's xenon or
10 krypton gas -- needs to be taken into
11 consideration. And of course, like all other
12 forms of exposure, uncertainties in the external
13 dose calculation is attempted -- we attempt to
14 address that in the technical basis document.

15 Occupational internal dose is probably the
16 most difficult thing to reconstruct. And as Dr.
17 Toohey mentioned earlier, these things are
18 difficult to decipher. You get bioassay cards
19 that are 50 years old with cryptic notations.
20 Sometimes you get results that don't have units
21 of measurement, you just get a number -- five,
22 four -- I mean you really don't know. A lot of
23 research needs to go into determining what that
24 really means and deciphering these codes. You
25 know, I've seen cards -- as Dr. Toohey mentioned,

1 A, B, C, D, or 1, 2, 3, 4. Sometimes they use
2 special notations for radioactive materials.
3 Uranium was not always called uranium. I mean
4 they had special notations -- for security
5 reasons, I suspect -- back in the early days for
6 the types of materials that were -- that workers
7 were being exposed to.

8 The method of analysis needs to be taken into
9 consideration, whether it was a fluorometric
10 technique or whether it was a gas flow
11 proportional count or measure -- alpha
12 measurement of a deposit urine sample on a plant
13 check -- all needs to be taken into account. And
14 wherever there's a question, the technical basis
15 document will, again, err on the side of being
16 favorable to the claimant.

17 We've got some examples. For example, at the
18 Y-12 facility the detection limit appears to have
19 been listed as 40 disintegrations per minute for
20 an alpha measurement in urine in the 9150/60 time
21 frame. That's a pretty high detection limit. We
22 suspect that it's much better than that, but we
23 cannot find any evidence that there's a
24 statistical analysis that demonstrates it's any
25 better than that, so that's what the technical

1 basis document indicates that we should use.

2 And again in the occupational internal area,
3 source term information by facility and process.
4 You know, what were the nuclides that were at the
5 site, where were they, during what time frame and
6 what was being done with them. I mean that's
7 probably some of the more important types of
8 information to be described, if there were no
9 monitoring data available for the workers.

10 And again, uncertainty in the internal world.
11 That's probably the most difficult thing to put
12 an uncertainty on. As Dr. Till mentioned
13 earlier, the ICRP has never come out with a
14 concrete statement as to what the uncertainties
15 are associated with internal dose. And we're
16 actually wrestling with that a bit right now. I
17 think we're getting close to putting some
18 brackets on it, but it's been the subject of some
19 discussion among our health physicists.

20 Okay. If you're monitored and you had a
21 badge, you know, you need to be able to interpret
22 that badge, so the site profile's going to have
23 the type of radiation energy -- the range of the
24 energies for photons and neutrons. You know, as
25 some of you are aware, we need to know the energy

1 interval that you were exposed to for -- whether
2 photons or neutrons, because that will have a
3 direct result or effect on your probability of
4 causation calculation. By labor category, if we
5 know that, we'll tend to describe that in the
6 document, and exposure geometry's pretty
7 important. Whether, you know, you were facing
8 the reactor shield wall or whether you were
9 working in a rotational geometry, all those
10 factors we try to put in the document so that the
11 professional judgments exercised by the health
12 physicist in doing the dose reconstruction are
13 somewhat consistent.

14 Dose correction factors, we've heard talks
15 about those before, but those are in there. You
16 know, how we convert a dose that's measured on
17 the badge to a dose to the prostate or to the
18 bladder, that sort of thing.

19 Handling of missed dose, you know, the
20 detection limits are in there, the badge exchange
21 frequencies. Dosimeter correction factors,
22 sometimes the dosimeters couldn't measure what
23 they intended to measure -- 17 keV photons at
24 Hanford in the early days comes to mind. One
25 needs to know what to do with that, and how does

1 one assign a dose to a worker? Well, hopefully,
2 you know, we're including that in there and -- as
3 is proper. Neutron dosimetry is another problem
4 area that we tend to flesh out in these
5 documents.

6 And again, putting the uncertainty with the
7 dose is -- to the extent possible, is included in
8 these documents.

9 Well, I mentioned that we're trying to do
10 these in parallel and get these out as fast as
11 possible. This slide is valid as of July 14th,
12 so it's changed somewhat, but these are the top
13 11 DOE sites and the number of claims from those
14 sites. And you see the bottom line is that if we
15 develop site profiles for 11 DOE sites, we
16 theoretically could produce dose reconstructions
17 -- or at least initiate them -- for over 10,000
18 claimants. So you know, it's not as daunting
19 maybe as it sounds. I mean we can do 10,000 with
20 11 site profiles, that's a pretty good number.
21 It doesn't address the other ones yet, but
22 nonetheless, if we can get these documents out in
23 a short order, we could start moving these
24 forward.

25 One of the ones that we -- we've completed an

1 AWE site profile for Blockson Chemical, which --
2 not Blockson Chemical, Bethlehem Steel, which the
3 Board heard about a couple of meetings ago.

4 Savannah River Site is the first DOE site
5 profile that's been completed, as of July 15th.
6 It's out there on our web site, as we discussed.
7 It covers operations from 1952 to the present at
8 29 separate facilities, all the major facilities
9 on-site are addressed in some way, shape or form.
10 It's a fairly comprehensive document. Rev. zero
11 came out at 188 pages. It's very technically
12 detailed. It was not written from a layman's
13 perspective, although there is an executive
14 summary that is fairly readable.

15 Just a few of the highlights. It does cover
16 environmental dose on about any location on-site,
17 which was based on an adaptation of the CDC
18 studies of effluent releases by Dr. Till's
19 organization when they did the Savannah River
20 Site dose reconstruction. It's a little
21 different. You know, off-site -- fence-line and
22 off-site dose was reconstructed by Radiation --
23 or Dr. Till's organization. We actually had to
24 adapt those releases and move in and do some
25 local area doses, based on their previous work.

1 There was a discussion on that at the health
2 physics meeting in San Diego, if any of you saw,
3 I thought it was pretty impressive.

4 The document does describe photon/neutron
5 energy distributions and ratios by areas for all
6 those facilities over the entire operating
7 history of the plant. I guess I should be a
8 little clearer than that, though. There are a
9 few gaps. I mean we decided that we were not
10 going to have these things -- we're not going to
11 wait till every piece of information was complete
12 to move it out. But the idea was that where
13 there are some gaps in information that are
14 missing, we've identified in there and go back
15 and put it in later. So there are a few areas
16 that are maybe not covered at this point, but
17 we'll add them as we can.

18 And from the internal dosimetry perspective,
19 there's some documentation that contains the
20 isotopic activity fraction by area, what isotopes
21 were present, at which areas and when.

22 Just to give you a flavor, this is a
23 controlled document. This is the cover page of
24 the Savannah River site profile document. Again,
25 it is written by ORAU and signed by the task

1 manager for the project and then Dick Toohey and
2 I are involved in the approval process, once both
3 of our health physics staff have reviewed them.

4 You'll see that we do have -- there's an
5 executive summary that I think is fairly
6 readable. Then the rest of the document consists
7 of, as you see, Chapter 2, occupational medical
8 dose, occupational environmental dose, internal
9 dose and external dose. So it's a pretty good
10 compendium, I think, of what happened
11 radiologically -- occupational radiologically at
12 the Savannah River Site over time. And then
13 there's a number of appendixes that are there
14 that discuss things like facilities, processes
15 and that sort of thing.

16 These are controlled documents, as I
17 mentioned. Once they're issued, you know,
18 they're maintained. Only -- you know, the dose
19 reconstructor should only be working with the
20 latest revision of the controlled document, so
21 when ORAU distributes it, they make sure that,
22 you know, that document is in effect in the
23 field. And if it changes -- for example, we're --
24 - I think revision one is being worked on
25 currently for the Savannah River technical basis

1 document. It's going to add another 50 pages of
2 data to help interpret internal doses. When rev.
3 1 comes out, then all dose reconstructors will be
4 made aware that, you know, as of this date, that
5 is the document that should be used to perform
6 dose reconstructions.

7 This is just a listing of the DOE site
8 profiles that are currently being developed, and
9 the contractor or subcontractor that's working on
10 them at this time, and the lead person who is
11 assigned to that dose reconstruction. Not shown
12 on here is the lead NIOSH person who works with
13 the lead ORAU person in getting these things
14 completed. But you can see that we've got all
15 these facilities covered. They're going in
16 parallel as we speak, so we will cover whatever I
17 showed on that first slide, something in excess
18 of 10,000 DOE claims -- DOE site claims could be
19 processed -- or at least initiated, given this.

20 The AWE sites are a smaller percentage of our
21 claims, I forgot what the statistic was, but 12
22 or 14 percent, something thereabouts. And so
23 this represents the number of claims from the top
24 ten Atomic Weapons Employer sites. You can see
25 the number totals about 1,200 or so. So you

1 know, not a tremendous number of claimants, but
2 that doesn't mean of course they're not important
3 to the individual claimant. They're just as
4 important as a DOE site. So we do have -- or
5 ORAU actually has in process a number of these
6 AWE sites right now. Bethlehem Steel of course
7 is done, so we have moved the majority of the
8 Bethlehem Steel claims through the process.

9 I think Dr. Toohey mentioned earlier Blockson
10 Chemical is in our hands for review, as well as
11 Huntington Pilot Plant. The other ones are in
12 various states of assemblage. They are trying to
13 take advantage of the process where these -- most
14 of the AWEs were uranium facilities and they did
15 sort of limited scope work, whether it was, you
16 know, making rods or producing uranium product,
17 uranium metal drums. They tend to fall into
18 similar categories, although they're not exactly
19 the same. One has to be careful about the level
20 of plutonium contamination that may be present in
21 the urine, or uranium, at the time the facility
22 was producing, the degree of enrichment, those
23 types of things need to be considered. But I
24 think there can be sort of a skeleton approach,
25 and then we can work out the details as to the

1 other factors that may contribute to the
2 claimant's dose.

3 This is a listing of currently the four AWE
4 sites that are under development, or one's done
5 and three more under development. And then just
6 a little slide showing the sites that are similar
7 to Blockson, that we feel we can use a similar
8 approach to dose reconstruction, and the sites
9 that we believe had similar operations to
10 Bethlehem Steel. So between the 10,000 DOE site
11 -- DOE claims and the 1,200 or so AWE claims,
12 we've got a good percentage of the claims
13 covered.

14 The good part of the story is these cover
15 that many claims, but then what Dr. Toohy talked
16 about earlier with the efficiency process is also
17 going to add some more claimants where we feel we
18 can move people through without actually having a
19 technical basis document or site profile. So
20 we've got the vast majority of the claims covered
21 with these things, although there's always going
22 to be these few that are going to be problematic
23 for us.

24 And I think that's the last slide, if I'm not
25 mistaken. Yeah. Well, I think I've kept us on

1 reasonable time for the lunch hour. If there's
2 any questions --

3 **DR. ZIEMER:** Yeah, thank you, Jim, I think we
4 do have a little time for questions if we have
5 any.

6 Jim Melius.

7 **DR. MELIUS:** Just to back up a little bit, if
8 I recall correctly, the original plan was that
9 these site profiles would be done sort of
10 sequentially, not as a group like this. And that
11 they would sort of be built up from the
12 individual dose reconstructions and the
13 information and they would gradually come into
14 play. So I think that -- is that correct or -- I
15 mean this -- is this a change in plan? I'm just
16 trying to get a handle on --

17 **DR. NETON:** Well, partially correct. I think
18 the concept of doing them sequentially was in the
19 plan, although we thought we might do a few at a
20 time, but with -- to step them up and to get them
21 all done in parallel is somewhat of a change in
22 direction. But you see we've added staff to do
23 that and we believe we need to do it to get the
24 numbers out the door.

25 To base them on the dose reconstruction and

1 the worker profiles, I think is what you're
2 alluding to, was really not the idea. The idea
3 was to have the site profiles in place so that we
4 could move claims, process claims, and as we got
5 experience with exposures from those workers who
6 were being processed using the site profiles, we
7 could start populating these worker databases or
8 worker profile databases. And in fact, we're
9 meeting next week with ORAU programmers to help
10 establish the overview of that database. We've
11 put some stuff in there, but we feel we have to
12 have a road map, you know, to get these things
13 completed.

14 Until you get a number of dose
15 reconstructions out the door and the data are
16 keyed in and entered, we can't really start doing
17 the worker profiles.

18 **DR. MELIUS:** But -- you can't start --

19 **DR. NETON:** We can't establish worker profile
20 databases until we do dose reconstructions.

21 **DR. MELIUS:** Oh, okay, I understand now.
22 Okay. Okay. I understand.

23 So then -- just so I understand then, these
24 site profiles are sort of a technical resource
25 document for the people doing individual dose

1 reconstructions, and then they will allow you to
2 -- based on that, to complete your individual
3 dose reconstruc-- to complete all the Y-12...

4 **DR. NETON:** That's the plan, although I have
5 to put a little bit of a proviso on there. There
6 may be some dose reconstructions that can't be
7 done even though the site profile is there. I
8 mean you've got all the information, but if the
9 person -- it may be more difficult to do -- you
10 may need more information than what's in the site
11 profile, let's put it that way. The person may
12 have had some very unusual incident that they
13 were involved with that we need to -- that might
14 not be in here. I mean this sort of covers the
15 standard operations at the facility and the
16 standard work practices. But if there's some
17 unusual circumstance, it may take a little longer
18 and a little more investigation to complete a
19 claim.

20 **DR. MELIUS:** And presumably also that once
21 the SEC reg comes out that that will -- you know,
22 there may be some numbers of people for whom a
23 individual dose reconstruction cannot be
24 completed.

25 **DR. NETON:** That's always a possibility.

1 **DR. MELIUS:** Yeah, and fall into -- to that.
2 Okay.

3 Secondly I'd like to ask you about how the
4 information's being gathered for these? It seems
5 to me that it's -- appears to be, given the time
6 frame involved, mostly a what's available in
7 terms of summary reports. Is that true or -- I
8 don't -- I haven't had a chance to read in detail
9 the Savannah River -- but it appears to be mainly
10 a paper collecting --

11 **DR. NETON:** Much of it's a paper review. We
12 have literally -- I'm not exaggerating when I
13 think I say tens of thousands of pages of
14 information in our database. But there are site
15 contacts or site conference calls set up with
16 current people at the facility to discuss -- I
17 know for Savannah River this is true. You know,
18 we had numerous discussions with them related to
19 their processes and that sort of thing. So it's
20 not merely a paper study, but it is primarily
21 based on paper -- paper data capture.

22 **DR. MELIUS:** Were any labor representatives
23 included in any of those -- that outreach effort?

24 **DR. NETON:** Not to my knowledge, no.

25 **DR. MELIUS:** Is there any plan to do that in

1 the other -- all the many others that you have
2 underway?

3 **DR. NETON:** No formal plans at this point,
4 but certainly if labor representatives had
5 information that were useful, we would -- we
6 would consider it.

7 **DR. MELIUS:** Well, it seems to me that from
8 your slide you were saying that you'd consider
9 information other people submitted, but it's a
10 passive process, so -- I guess I'm trying to
11 understand how -- how these -- how people get
12 into it, into this process. It seems to me it's
13 a very closed process. You have only an internal
14 review, though I -- I'm curious about this health
15 physics society review of the document that you
16 mentioned. But before -- talk about that, what -
17 - I mean -- it's a closed process. True? I mean
18 it's --

19 **DR. NETON:** I think --

20 **DR. MELIUS:** -- between NIOSH and ORAU and
21 this -- you know, these contractors that you've -
22 - ORAU's hired to do this.

23 **DR. NETON:** Yeah, I don't think I'd
24 characterize it as a closed process, but it is a
25 process that typically does involve health

1 physicists who are knowledgeable about the
2 exposure conditions at the facility. And it is
3 true that we have not gone out and solicited
4 labor's input on these documents.

5 **DR. MELIUS:** Do you think there might be some
6 value in soliciting input from not only labor
7 unions, but other people that are familiar with
8 the site that -- you know, retired technical
9 people, other people around a site that might be
10 -- provide useful information --

11 **DR. NETON:** Oh, yeah, I --

12 **DR. MELIUS:** -- particularly in what's not
13 available or what might not be readily available?

14 **DR. NETON:** I think that's useful. I think
15 we're -- it's a balancing act, you know, getting
16 these things completed and -- and using them.
17 But they're dynamic documents, as well. And as
18 we have time to do that, I think it's a
19 reasonable -- reasonable idea.

20 **DR. MELIUS:** So it's going to depend on when
21 you have time to -- I'm just trying to understand
22 the process. I don't --

23 **MR. ELLIOTT:** If I could add a comment here,
24 Bethlehem Steel we did use information that was
25 contributed by a worker.

1 **DR. NETON:** A claimant.

2 **MR. ELLIOTT:** A claimant. So it's not -- you
3 know, it's not fair to say that we don't accept
4 that and use it. We do. Jim mentioned that
5 earlier. Savannah River Site is not -- does not
6 have an organized labor group, per se, there.
7 They're largely unorganized in their work force,
8 but we did not take advantage of the opportunity
9 to seek or solicit information from anyone other
10 than the people Jim's mentioned at that site.

11 However, once these documents are on the web
12 site or available to the public, we certainly
13 welcome any kind of comment or input that could
14 be garnered from those that we didn't touch.

15 **DR. MELIUS:** Well, Larry, I'd like to --
16 there's nothing I saw in the beginning of the
17 document -- maybe it's buried on page 150 -- that
18 indicates you're soliciting input or interested
19 in input nor did I see it when it was posted on
20 the web site. It was post-- put up on the web
21 site as a completed document. In fact with this
22 -- I happen to know what a controlled document is
23 from my old bureaucratic days, but -- in the
24 government, but to me it looks like a very
25 official, final document and there's really no --

1 not even a hint that you're looking for input
2 into that. And I think that needs to be
3 corrected.

4 I'd also like to add -- and again, I haven't
5 read Savannah River, but are there -- is there
6 any information in the document that indicates
7 what the sources of information were,
8 particularly the individuals that were talked to?
9 You talked about some conference calls or some
10 attempt to reach out to the...

11 **DR. NETON:** Yes, I think that -- well, where
12 there are cital (sic) references, they're
13 certainly in there. I'd have to defer to Judson
14 Kenoyer on whether -- I forgot whether we've
15 cited contact information.

16 **MR. KENOYER:** I know in the original --

17 **DR. ZIEMER:** Judson, you may need to use the
18 mike here, please.

19 **MR. KENOYER:** I'd have to check on the final
20 document as it was printed, but I know in the
21 original draft we referenced specific
22 conversations with people on site.

23 **DR. NETON:** I was pretty sure we did, but I
24 wanted to make sure.

25 **MR. KENOYER:** Some of the most valuable

1 information we retrieve is from the direct
2 interaction with people that worked on-site in
3 the early years. Certainly that's our biggest
4 challenge, to get data describing -- or
5 information describing the systems that were used
6 in the early years. And we've gone to more and
7 more interviews, face-to-face interactions with
8 people that have since retired but are still
9 around.

10 One example is this week we are interviewing
11 Jan P. Lawrence at Los Alamos, a key individual
12 in the external and internal dosimetry programs.

13 **DR. MELIUS:** I guess what I'm concerned about
14 is that people don't know you're doing the
15 document, don't have any information on the
16 process or what's going on, how do they know to
17 even contact you or how do you know to contact
18 them? It's a very sort of hit and miss and I
19 agree, we're not going to find everybody that has
20 -- may have valuable information and you may have
21 people that end up with not very valuable
22 information. But if there's no attempt for
23 outreach or -- of this and -- and I think that
24 goes through -- right through from the start of
25 the document. Again, okay, these are dynamic

1 documents. Why not make it -- tell people,
2 announce to people, get the information out that
3 you are soliciting further contributions to this
4 -- terms of information and -- and so forth. And
5 I don't know whether that's best -- you know, at
6 what step in the process it's best done. I'm
7 concerned when you're rushing through something
8 in, you know, three or four months, it doesn't
9 leave much time. And albeit there is -- you need
10 to get the program going, but that ought to be
11 balanced by how good and comprehensive the
12 information -- how complete the information is so
13 we don't make mistakes and leave out valuable
14 information that was -- you know, might have
15 changed somebody's dose reconstruction. And I
16 think some more active outreach would be useful
17 for that purpose.

18 **DR. NETON:** I think you make a good point and
19 we certainly will consider that. But I will say
20 that, you know, we would not release the document
21 unless we were very confident that we had
22 captured the essence of the exposure profile of
23 the site. But if information did come to light,
24 we are committed to going back and re-evaluating
25 the claims that were processed, with that new

1 information, to make sure that someone was not
2 inappropriately, you know, characterized for
3 their exposure.

4 **DR. MELIUS:** Yeah, I'm not trying to
5 characterize your intent or whatever. I think
6 your intentions are good. But I think we have a
7 whole history of review documents being put out
8 about these sites that are -- been less than
9 complete, with a lot of missing information. So
10 I think having a public process to this and an
11 active outreach would be very helpful.

12 I'm also a little concerned about -- I
13 presume there's no external peer review, and I
14 think that's something that might be considered
15 as, again, a way of soliciting both technical
16 input in terms of what you're doing, as well as,
17 you know, soliciting more information from
18 people. You know, maybe we've used up all the
19 available health physicists and maybe peer review
20 would be hard to do, but -- I guess I was struck
21 by the fact that you went to the health physics
22 society, you mentioned that you had lively
23 debate. I don't know what that means, but that --
24 - I assume it means you got some input in terms
25 of at least that particular calculation that you

1 had done. And again, I don't know whether Dr.
2 Till's group or Dr. Till was contacted about what
3 you -- or you know, solicited about the way you
4 were using the original data and they with-- you
5 know, maybe some ideas they might have, but it
6 seems to me that there's some value to a
7 scientific peer input into this process at some
8 point.

9 **DR. NETON:** Well, at some point we have to
10 draw the line. I mean we are hiring a contractor
11 to do nothing but review these technical basis
12 documents in probably three months from now. So
13 to layer review upon review does sort of impede
14 the progress. But your point's well taken.

15 **DR. MELIUS:** If they're -- living documents.
16 I was also -- my understanding was there was a
17 number of health physics society presentations
18 that were made by --

19 **DR. NETON:** Yes.

20 **DR. MELIUS:** -- the NIOSH staff. Are those
21 available at all to those of us who didn't get a
22 chance to go to wherever?

23 **DR. NETON:** I don't believe they're on our
24 web site, although we can certainly do that and
25 make them -- are they out there, Dick?

1 **DR. TOOHEY:** Let me just comment -- the ones
2 that were made by ORAU staff I think are on the
3 ORAU COC* web page. I know mine is. It's
4 certainly our intent to post them out there.

5 **DR. NETON:** We'll make sure that we put all
6 those on our OCAS web site for public viewing.

7 **DR. ZIEMER:** I might add, Jim, that the
8 health physics society doesn't publish
9 proceedings of their meeting, but they do publish
10 the abstracts of each of those papers. They are
11 basically individual submissions, and I don't
12 think the -- this was not a formal review by the
13 health physics society.

14 **DR. NETON:** No.

15 **DR. ZIEMER:** What you had was discussion at
16 an open meeting --

17 **DR. NETON:** Exactly.

18 **DR. ZIEMER:** -- when a paper was presented.

19 **DR. MELIUS:** Yeah, but -- yeah, I understand.
20 I understand. I just think -- thought I was
21 making the point that such a discussion is
22 valuable, as would additional peer review and
23 additional input into this process.

24 Finally I'd like to just go back to at least
25 this whole issue of conflict of interest and

1 transparency of the process. I think all of
2 these things we've been talking about, the
3 questions I mentioned, are critical to the
4 credibility of this process. You're going to be
5 basing a lot on these documents, and that albeit
6 there's, you know, individual dose reconstruction
7 that'll go on and opportunity to question issues
8 and provide more information, but a lot of what
9 you do and a lot of the credibility of this
10 process is going to be dependent on the -- these
11 documents. And to have them done by -- without
12 people knowing who's involved and this whole
13 issue of potential conflict of interest, I think
14 is a serious mistake to be made, and I think
15 it'll cause serious issue-- serious questions to
16 be raised about the credibility of the whole
17 process, particularly if the wrong information,
18 wrong people are involved, or misinformation gets
19 out in a very selective way about who's involved
20 and then why has this been kept secret. And I
21 really think you need to seriously consider how
22 you open up this whole process, including the --
23 how you solicit information, how you get the
24 review done, how you continue to solicit input,
25 as well as the transparency for the people

1 involved in the process.

2 **DR. NETON:** Okay.

3 **DR. ZIEMER:** Thank you, Jim. Gen and then
4 Mark, and then we need to break for lunch. We
5 can return to this if there's others that want to
6 comment.

7 **DR. ROESSLER:** My question is about radon
8 doses. I assume some of these facilities do have
9 enhanced radon. How are you getting the
10 information to calculate those radon doses and
11 how are you taking into account what the non-work
12 place radon might have been, which to me should
13 not be a part of the radon dose attributed to the
14 work place.

15 **DR. NETON:** Right. Well, there are radon
16 monitoring data for a number of facilities. I
17 know Fernald has some -- minimal data, but at
18 least we know what -- what the upper limits were
19 in some facilities. I know Mallinckrodt has some
20 radon monitoring data. So to what -- to the
21 extent it's available, we'll use it to model what
22 the exposures were. I suspect if we didn't have
23 any radon information and we knew how much radium
24 was there, we could sort of back-calculate based
25 on emanation rate and equilibrium situation, what

1 could have been there at the upper limit. So we
2 do intend to use it. It's included in the
3 technical basis document if it's occupationally-
4 derived.

5 The trick is, I think -- you know, your
6 second part of your question, which is what --
7 what portion of the radon exposure at these
8 facilities is occupationally-derived. And in
9 fact, we're still wrestling with that concept.
10 There are some areas where there are tunnels that
11 were drilled into the ground to do testing of
12 weapons. That's not technologically-enhanced
13 radon, but it is a tunnel, and is that an
14 occupational exposure or not. We are currently
15 formulating a policy on that position.

16 **MR. GRIFFON:** Just a quick one maybe, and
17 maybe if we need to we can continue after lunch
18 or whatever. But I'm seeing a new parenthetical
19 phrase in some of those overheads -- at least new
20 from my memory on some of your previous
21 presentations. "If readily available" keeps
22 cropping into many of these overheads now.

23 **DR. NETON:** Yeah.

24 **MR. GRIFFON:** And I'm wondering if you can
25 define for us -- sort of like sufficient

1 accuracy, you know. Can you define "readily
2 available"?

3 **DR. NETON:** I can attempt to. The idea there
4 is that, you know, we have to produce these in a
5 reasonable time frame. And if the information
6 are somewhat consolidated and available, either
7 electronically or in one room as paper records,
8 we would consider using them in the technical
9 basis document themselves. But if the
10 information, as I mentioned, is distributed about
11 the site and available in 300 facilities that are
12 contaminated facilities, we just don't feel at
13 this point that it's beneficial to hold up the
14 technical basis document to retrieve all those
15 records.

16 Now as far as a dollar figure or time frame,
17 we really haven't established that. Fortunately
18 these things seem to sort of be dichotomous.
19 They either have an electronic database or they
20 don't, and the records are not retrievable. So
21 we haven't had to really define what -- you know,
22 what that cut point is.

23 **MR. GRIFFON:** And is that something -- for
24 instance, if you identify a set of records that
25 may not be easily retrievable, where -- where is

1 the responsibility drawn for -- for collecting
2 those rec-- does DOE have a role in this
3 collection process?

4 **DR. NETON:** DOE has a role --

5 **MR. GRIFFON:** I'm sure they might want to be
6 reimbursed for their efforts or -- or --

7 **DR. NETON:** Right.

8 **MR. GRIFFON:** How does that work?

9 **DR. NETON:** DOE has a role in making those
10 records available for us to capture. So they
11 would consolidate them to a certain point, but
12 then we would go to the site and do a data --
13 what we call a data capture effort, which is to
14 scan all the records, if possible, and obtain
15 images of those records.

16 **MR. GRIFFON:** I guess --

17 **DR. NETON:** Judson might have a slight
18 correction there, but I think that's fairly
19 accurate.

20 **MR. KENOYER:** That is accurate. What I'd
21 like to do is add to that, though. Remember we
22 talked about these being dynamic documents.
23 Readily available really fits into the rev. zero
24 zero, because we're continuing the efforts to
25 search out additional data.

1 **DR. NETON:** Yeah.

2 **MR. KENOYER:** Good example would be data on
3 Mallinckrodt. I know that there's some up in DOE
4 headquarters, but they're mixed in with
5 classified information. It's just going to take
6 time to retrieve it. We'll produce rev. zero
7 zero of the Mallinckrodt TBD, but we'll pursue
8 getting the other data and if it changes the TBD,
9 we'll -- that'll be in rev. zero one.

10 **MR. GRIFFON:** I guess, you know, just
11 referring back to some of what Jim said, you
12 know, some of the concerns early on in this
13 program that have been expressed is that past
14 reports and past DOE databases may -- may be at
15 least suspect or -- and part of the reason for
16 this independent effort would be that we, at the
17 very least, cross-reference or validate or
18 verify, if we're going to use those numbers for
19 determinations. And I guess some of what I -- at
20 least in this rev. zero of Savannah River, I
21 noticed that air monitoring --

22 **DR. NETON:** Was not readily available.

23 **MR. GRIFFON:** -- was basically skipped over.
24 I mean it seems that a lot of the records are
25 going to be difficult to get to, if in fact you

1 do attempt to get them. But I would argue that -
2 - at least at some quality control level -- it
3 would be a valuable exercise to verify the
4 bioassay records.

5 **DR. NETON:** Oh, yeah, we certainly intend to
6 do that. I mean we'll go back and, as the
7 information becomes available, bounce it against
8 our TBD.

9 Let me say, though, one point -- it's been my
10 experience that when we -- if we construct a
11 technical basis document and we are lacking
12 information, we are claimant-favorable in our
13 approach. And at least in two instances now, I
14 know as additional data became available, it
15 would tend to reduce the doses or our estimated
16 exposures to the claimants rather than increase
17 them. So it's -- they tend to be more claimant-
18 favorable the less data you have.

19 **MR. GRIFFON:** Last pre-lunch question. If --
20 you know, I guess some of my concerns are -- and
21 you've heard these before -- is the notion of
22 missing the trees for the forest, and the fact
23 that -- this goes back to the question of
24 unmonitored workers, and you say when you don't
25 have other records, you may rely on source term

1 data. When you define source term data, I would
2 imagine that this level, especially in rev. zero,
3 you're talking about building -- a building, or
4 as -- or -- or -- well, I -- well, I don't know,
5 but the question is, you know, at least my
6 experience is that sometimes within processes you
7 find different concentrations, different
8 accumulations of radionuclides so your source
9 term can vary over a process and over time and
10 how --

11 **DR. NETON:** Right.

12 **MR. GRIFFON:** -- how do you define, you
13 know...

14 **DR. NETON:** Well, but I think, again, you'd
15 see that if we did -- if you did a dose
16 reconstruction based on source term data, it
17 would tend to be very claimant-favorable. If we
18 didn't know that the person worked near -- we
19 would come up with a maximum exposure scenario,
20 essentially, given that source term. And
21 essentially, if we couldn't prove otherwise,
22 assign it to the claimant and use that for --

23 **MR. GRIFFON:** Yeah, my example -- being very
24 specific, if you assign a maximum, you know, for
25 some of the recycled fuel stuff, we know that

1 some of the transuranics will isolate in certain
2 areas and certain processes.

3 **DR. NETON:** Right.

4 **MR. GRIFFON:** If this individual worked
5 around some of those processes but you give them
6 the -- you assign them the -- you know, without
7 knowing that, you assign them the average, you're
8 potentially, you know, missing --

9 **DR. NETON:** Well, that's an example where
10 it's a bad dose -- it's a bad profile. Right? I
11 mean we haven't done our job. And if we knew --
12 if you know that material's there and -- for
13 instance, we didn't know that the worker didn't
14 work at one of -- if we couldn't establish he
15 worked at a trap or not, where maybe the
16 neptunium or whatever concentrations were
17 extremely high, we almost have no choice but to
18 then to say okay, that's -- that's a --
19 potentially your exposure scenario, you know. I
20 mean there's just no way around that.

21 **MR. GRIFFON:** Okay. I guess it's -- it seems
22 to me that defining some of these source terms
23 can be a complex exercise 'cause some of these
24 facilities over time --

25 **DR. NETON:** Sure.

1 **MR. GRIFFON:** -- very dynamic and...

2 **DR. NETON:** Yeah, absolutely. But I think if
3 you look through our dose reconstructions you'll
4 find that they tend to overestimate exposures in
5 general.

6 **DR. ZIEMER:** Let's now recess for lunch. I'd
7 like to ask if we could still shoot for 1:30
8 return time. It does shorten lunch period a
9 little bit, but try to keep us on schedule.
10 Thank you.

11 (Whereupon, a luncheon recess was taken.)

12 **DR. ZIEMER:** I wanted to give an opportunity
13 for any additional questions for Jim. We were
14 pushing the lunch hour and needed to recess. But
15 are there any remaining questions for Jim Neton
16 and -- relative to his presentation -- comments
17 or questions? Yes, Jim Melius.

18 **DR. MELIUS:** I have one.

19 **DR. ZIEMER:** And --

20 **DR. MELIUS:** I don't think -- Jim can stay
21 there, that's fine. Either one.

22 **DR. ZIEMER:** Either place, wherever you're
23 comfortable.

24 **DR. MELIUS:** It's sort of a follow-up to what
25 I asked before. I came to me over lunch. But I

1 guess I get -- I get concerned, I think others of
2 us are concerned about sort of false negatives,
3 that we -- you'll miss important information
4 that might affect some proportion of the dose
5 reconstruct-- individual dose reconstructions
6 that are done at a particular site because the
7 information's not readily available, whatever.
8 And I guess my question is have you thought about
9 some sort of a decision plan or approach that --
10 for -- you finish the site profile with whatever
11 information's available. You're going through
12 doing the dose reconstructions and there's a
13 group of workers in a particular part of the
14 facility that there's a great deal of uncertainty
15 about their -- the available exposure information
16 for them, or that requires further work, or based
17 on individual dose reconstructions they're not in
18 the high category, those that are -- will be
19 compensated, or the low -- but they're sort of
20 closer to the decision point that you may -- you
21 might hold up their dose reconstructions until
22 you've done more work on the site profile? I
23 guess I'm worried about this, you know, sort of
24 steaming through, doing all X hundred cases from
25 some facility and then finding out that well, we

1 later found, you know, information that for 50 of
2 them was -- really changed how we did it, or
3 maybe even for five. 'Cause I think to have to
4 go back and correct that kind of error would be
5 problematic, and I think it might be taken care
6 of up front as you're sort of developing your
7 document.

8 **DR. NETON:** I think I have your question. Is
9 it if we have a site profile done and we have a
10 group of workers that we're trying to move those
11 dose reconstructions through the process but we
12 feel that the site profile is not sufficient to
13 put them on one side of compensability or not,
14 what would we do with those claims?

15 **DR. MELIUS:** Yeah, I mean or that --

16 **DR. NETON:** Yeah.

17 **DR. MELIUS:** -- might be built into the
18 process that we're not going to process these
19 because --

20 **DR. NETON:** Right.

21 **DR. MELIUS:** -- there's a great deal of
22 uncertainty about a particular -- or availability
23 of records for a particular building or, you
24 know, particular type of exposure.

25 **DR. NETON:** Yeah, I think that's correct. We

1 would not move them through just for the sake of
2 moving them out the door and checking the box or
3 something to that effect. Those would be held up
4 until we had sufficient information to -- so that
5 Labor could make a decision, you know, one side
6 or the other for compensability. So you know,
7 I'm not sure what else to say on that.

8 **DR. MELIUS:** No, no, that's fine. I'm just
9 thinking that ought to be communicated as part of
10 this proc-- I'm just saying --

11 **DR. NETON:** Okay.

12 **DR. MELIUS:** You're saying yeah, there are
13 limitations to these site profiles. They're not
14 final and we're continuing to seek information.
15 We're not going to inappropriately use them until
16 we're -- we feel that the information is
17 adequate.

18 **DR. NETON:** Right. I thought I -- I tried to
19 allude to that a little bit in my presentation
20 when I pointed out that -- for instance, if we do
21 a claim that was involved in an incident or
22 several incidents and they weren't covered in the
23 profile, you know, there's just no way we would
24 be able to move that claim without, you know,
25 obtaining additional information.

1 **DR. MELIUS:** Okay. Thanks then.

2 **DR. ZIEMER:** Henry Anderson.

3 **DR. ANDERSON:** Yeah, I just wanted to follow
4 up on that a little bit. I just quickly went
5 through the Savannah site review or base document
6 on -- and I had some difficulty identifying what
7 were the specific data gaps that you may have
8 identified. And I think, again, if it's going to
9 be a living document, it would be helpful, again,
10 from the standpoint of those individuals who
11 might, as we just talked about, not have their
12 claim finalized, it would be helpful -- almost
13 like a data call-in -- to say here's what we
14 currently have and here's some indications or we
15 believe there may be additional information that
16 we're looking for. I think that might be a more
17 -- trigger more people to send information in.

18 And then the second statement, I would just
19 ask is there have been quite a number of lawsuits
20 involved in the various sites, and as part of
21 that they typically have quite a bit of discovery
22 and documents are produced. And it would be ni--
23 and usually they're listed by some type of a
24 name. It might be useful as readily available
25 information to look at those to see if that data

1 and information is included in your site profile.
2 That's just a -- I would assume most of it is,
3 but there may well be some information there if
4 you have not mined those. I know in a lot of the
5 other litigation that's often turned out to be a
6 very useful source. It's very laborious to go
7 through, but it might be something to look at.

8 **DR. ZIEMER:** Okay. Thank you, Henry. Other
9 comments or questions?

10 (No responses)

11 **ADMINISTRATIVE HOUSEKEEPING AND**

12 **BOARD WORK SCHEDULE**

13 Thank you. Let's move on in the agenda then.
14 Our next item is some administrative issues. I
15 would like us to first turn to the charter, and
16 the reason I ask you to turn to the charter is to
17 make note of the fact that our charter, you know,
18 runs a two-year cycle. And if you look on page 3
19 of the charter, at least the version of the
20 charter that's in your book, you'll notice it's
21 dated August 1st, 2003, signed by Tommy Thompson.
22 So this is the current charter.

23 Now if you read through that, I note many
24 things haven't changed. For example, I notice
25 your compensation has not increased by cost of

1 living or any other factor, for whatever that's
2 worth, which apparently is not much.

3 What is different here in this charter is on
4 page 2 under the item called structure. And if
5 you read through structure, you will notice that
6 -- wait a minute, am I in structure?

7 **MR. ELLIOTT:** Second paragraph.

8 **DR. ZIEMER:** Second paragraph of structure,
9 yes. I was looking for something that is new in
10 our charter, and that has to do with specific
11 terms of the members. And Larry, could you speak
12 to that issue for us?

13 **MR. ELLIOTT:** Yes, thank you, Dr. Ziemer.
14 The -- in renewal of the charter, the White House
15 and the Department incorporated term --
16 membership terms for this body now. It wasn't
17 resident in the first charter. It is in this
18 renewal of the charter. We will be talking to
19 each individual Board member about the term of
20 membership that's been specified for you. This
21 is -- it's an HHS policy, as well as FACA, to
22 have term memberships. I think it perhaps is --
23 is something that was attended to at this charter
24 renewal that was perhaps lost in the initiation
25 of the first one. So as we go forward, we will

1 be contacting you individually and talking to you
2 about membership and term of membership.

3 **DR. ZIEMER:** Okay. And Henry, question or
4 comment?

5 **DR. ANDERSON:** Yeah, a question. Do you have
6 any thought as to how many terms one -- I mean
7 usually it's -- you know, I think a four-year
8 appointment. It's nice to know it's not an
9 endless appointment, from both sides. But
10 oftentimes they have -- but no more than two
11 consecutive terms, and I see they don't have any.
12 Do you see that as a -- when you say a term, do
13 you mean that everybody will only serve four
14 years?

15 **MR. ELLIOTT:** Well, I would direct your
16 attention to the way that paragraph starts. You
17 are Presidentially appointed and you serve at the
18 pleasure of the President. And the White House
19 has designated terms. They are going to be
20 staggered terms so that each year there will be a
21 moderate turnover of the Board, perhaps. In some
22 cases maybe the White House will say they want to
23 keep someone in place in membership. I believe
24 FACA says that you can -- as you noted, that you
25 can serve up to a specified number of terms or a

1 specified number of years.

2 **DR. ANDERSON:** Yeah.

3 **MR. ELLIOTT:** Also I would call your
4 attention to the last sentence in that paragraph
5 where it says terms of more than two years are
6 contingent upon the renewal of the charter, so
7 you know, there's a lot of factors that come to
8 play here in making these appointments happen.
9 And so I just wanted to call your attention to
10 this fact that in this charter renewal this now
11 exists.

12 **DR. ZIEMER:** Larry, it would be my
13 understanding then that the current Board
14 membership would be assigned varying terms, so
15 the whole Board does not get replaced at one
16 time. Presumably what, a third of the Board
17 every two years or something like that. Can you
18 speak to the issue -- has the White House made
19 such a determination already or are -- will that
20 be made soon?

21 **MR. ELLIOTT:** Yes, that determination has
22 been made and the way it was made, the Board was
23 grouped into three categories on an alphabetical
24 order, A to Z. The first grouping of four would
25 go off a year from now, second grouping would go

1 off two years from now -- with a possibility of
2 reappointment. This is up to the President, up
3 to the White House, so -- and the third grouping
4 would go off three years from now. So that's the
5 way this has been arranged in their appointment
6 cycle.

7 **DR. ZIEMER:** Thank you. Are there questions
8 or comments on the charter, or the terms?

9 (No responses)

10 Thank you. Now let me ask Cori if we have
11 additional -- or Larry, do we have additional
12 administrative matters at this time -- or
13 housekeeping matters?

14 **MR. ELLIOTT:** I don't believe that -- Cori's
15 standing back there shaking her head no, but I
16 would remind you all of our process of e-mailing
17 Cori or myself with your time of preparation.
18 Cori says she'll remind you with an e-mail
19 tomorrow morning. It's important that we get
20 your travel voucher in for -- back as soon as
21 possible so that we can -- this is very
22 important, so please hear me out. We're
23 approaching end of year, fiscal year closeout,
24 and so if you don't want the hounds coming after
25 you for your voucher info, please submit that so

1 that we can close the books on this fiscal year.

2 We do need -- perhaps not at this point, but
3 later before we depart today we need to figure
4 out what your next meeting schedule is, and I
5 think that may be dictated by perhaps the
6 discussion to ensue shortly.

7 **DR. ZIEMER:** Cori did ask all of us to send
8 her our schedules for the next -- I think for the
9 remainder of this calendar year. And if you
10 haven't already done that, you need to do that,
11 as well.

12 Do any of the Board members have any
13 questions on work schedule, administrative
14 procedures, housekeeping items?

15 (No responses)

16 If not, we'll proceed on the agenda and move
17 to the working session and -- on development of
18 the task order and I'll give the floor to Mark
19 Griffon. Mark.

20 **BOARD DISCUSSION/WORKING SESSION**

21 **DEVELOPMENT OF TASK ORDER**

22 **MR. GRIFFON:** Yeah, we -- we have several
23 items, including the homework assignment from
24 last night. But I thought -- I guess the way I
25 want to approach this is this morning the working

1 group met again and we went through the two tasks
2 that were handed around the table yesterday
3 morning, which -- which are for dose
4 reconstruction review and for procedures and
5 methods review. And I thought -- I think --
6 yeah, Cori's handing out -- we -- we worked and
7 edited those this morning and have them in more
8 final form. And my feeling is that I'd like, in
9 our time period that we have, to get as much --
10 items completed as we can. I think we have some
11 open-ended discussions on some things, which I'll
12 hold off a little, if we can. So I'd like to
13 start with discussions on those two tasks. And
14 then talk a little about the process of how we're
15 going to review these tasks and what that will
16 involve, and that may impact some discussions on
17 future meetings, et cetera. And then the --
18 there's a couple of other tasks that I've
19 developed real rough drafts of tracking tasks and
20 a site profile task, and then finally what --
21 some -- I think we need some follow-up discussion
22 on the question on interviews, or follow-up
23 interviews.

24 So -- but to start with, something that I
25 think is hopefully nearing a final draft, these

1 two tasks which just got circulated. I think I -
2 - maybe we can open up a discussion on them, and
3 the language should look very familiar by now to
4 people in these things.

5 To start, the one -- the first one, dose
6 reconstruction procedure and methods review, the
7 shorter one of the two, we added -- and I left
8 the -- I didn't accept the changes on the track
9 changes mode. I left the changes there so you
10 could see where we really edited this morning.
11 And Roy DeHart brought up a good point that, you
12 know, it seems like we should have asked the
13 contractor to, up front, establish a procedure by
14 which they're going to review all of NIOSH's and
15 ORAU's procedures and methods. And that
16 procedure would also be reviewed by the Board for
17 approval.

18 And in the bottom two sections you'll see
19 some editions on the period of performance and
20 the reporting and deliverable requirements. Give
21 you all a second to look at those.

22 (Pause)

23 **DR. ZIEMER:** Mark, while people are finishing
24 up reading that, I just want to ask a process
25 question here, and perhaps both to the working

1 group and to NIOSH staff. And that is, in terms
2 of the content and the form, does this meet the
3 requirements for a work statement? I assume it
4 does since you've had Jim and others working with
5 you on that. So this would meet those
6 requirements, in terms of the specificity and
7 detail -- level of detail. And presumably the
8 contractor would then take this and develop the
9 cost document for final approval. Is that
10 correct?

11 **MR. ELLIOTT:** Yes, the -- you're -- the Board
12 would deliver this -- a task order to the
13 contractor, who would then be allowed an
14 opportunity of perhaps two weeks to prepare a
15 proposal on how they would conduct the work
16 specified in the task, describe what skill
17 categories would be employed in that effort and
18 provide a cost estimate. And that would -- that
19 proposal would come back to whoever the Board or
20 whatever your process is going to be -- how it's
21 going to be specified, who will take that
22 proposal, evaluate and, if necessary, negotiate
23 it.

24 **DR. ZIEMER:** And then my related question --
25 again to staff and to Mark -- is that do we need

1 today to have an approved statement of work for
2 that purpose, or are we still looking at this as
3 subject to some final polishing? Are you simply
4 looking for Board input and reaction today or are
5 you looking for closure today?

6 **MR. GRIFFON:** I was hoping that for these
7 two, since -- that we need closure on these
8 today. Yeah, and move these forward, at least in
9 the system.

10 **DR. ZIEMER:** So at some appropriate point
11 when we think we're ready to do so, then we could
12 have a formal motion to approve the document.
13 Okay.

14 Mark, do you have any more comments on the
15 document, then we can put it on the floor for
16 formal discussion if you want to so move --

17 **MR. GRIFFON:** Yeah, I'd like to -- I'd like
18 to --

19 **DR. ZIEMER:** On behalf of the working group,
20 you move adoption of this statement of work?

21 **MR. GRIFFON:** Thank you for making -- yes.

22 **DR. ZIEMER:** That's what I thought you were
23 -- reading the body language.

24 **MR. GRIFFON:** Right.

25 **DR. ZIEMER:** And that basically is a motion

1 from a working group. It doesn't require a
2 second in that case, so it's on the floor for
3 discussion. This is only on the first statement
4 of work -- I'm trying to identify it -- as -- I
5 guess it's dose reconstruction procedure and
6 methods review --

7 **MR. GRIFFON:** Correct.

8 **DR. ZIEMER:** -- is the title of the statement
9 of work that we're considering now. And I think
10 we can both raise questions, you can ask for
11 clarifications, you can move for amendments to
12 this.

13 Robert Presley.

14 **MR. PRESLEY:** Where we have put in months, do
15 we need to go in and change that one month to 30
16 days, six months to so many days. Where you've
17 got two weeks --

18 **DR. ZIEMER:** Robert, identify the item here
19 for all of us.

20 **MR. PRESLEY:** Okay, period of performance,
21 second page.

22 **DR. ZIEMER:** Okay.

23 **MR. GRIFFON:** I would say -- I mean I would
24 say, similar to the original contract language
25 that we did, I think we can allow NIOSH to make

1 technical edits as long as they don't change the
2 -- you know, the nature of the -- and I think
3 that was done previously to tighten up some of
4 the language, so if that needs to be done, that's
5 fi-- you know, I would think that would be fine,
6 yeah.

7 **DR. ZIEMER:** Okay. Everybody understand the
8 question there? So you're not asking that this
9 language necessarily be changed, it's -- or are
10 you?

11 **MR. PRESLEY:** I think we need to ask legal
12 where we need to tie that down.

13 **MR. ELLIOTT:** I want to be clear on what
14 you're asking us to do here.

15 **MR. PRESLEY:** Where we have -- like one
16 month, do we want to tie that down to 30 days?
17 Especially where you have in there within six
18 months, that can float quite a bit within a six-
19 month period.

20 **MR. ELLIOTT:** Well, let me just suggest this,
21 that once your task has been developed, we would
22 then put that in front of the procurement office,
23 and any kind of issues like that -- it's going to
24 come from them, not us. And so the procurement
25 office will drive those kind of edits. If they

1 say hey, it needs to be so many working days
2 versus a calendar month, that'll come back from
3 them and we'll rely on them, if that's okay with
4 you all.

5 **DR. ZIEMER:** Right. So the intent is here
6 and they can polish that. Is that agreeable with
7 everyone? We can leave the language as it is for
8 the moment then. Okay.

9 Wanda.

10 **MS. MUNN:** This question may derive from my
11 lack of familiarity with the procurement process,
12 but I see no indication of establishing any
13 criteria for bidders here. Are we just going to
14 say anybody who thinks they can do this, do it?
15 Or do we establish criteria?

16 **MR. ELLIOTT:** Well, this is the next phase of
17 procurement. The first phase was to put a
18 request for proposals on the street, which you
19 did, that provided a boundary, if you will, about
20 the scope of work. Now within that scope of
21 work, once your contract is awarded, you're going
22 to give the contractor task orders. That's what
23 this is. And so there's no need for -- you know,
24 you're not -- even if this -- if this contract is
25 awarded to multiple awardees, they're still given

1 the same level playing field in one task. They
2 don't need that.

3 If I could also comment here on what I said
4 earlier about relying on procurement to help make
5 sure that we're following proper procurement
6 procedures, on the first page under purpose and
7 description paragraph, the second sentence -- The
8 task may be extended to be a periodic annual
9 review. I think we're going to have a little bit
10 of problem with that. You might want to think
11 about that 'cause you can't promise future work.
12 You can only task under one task. Now you can
13 resurrect this same task later, say -- say a year
14 or 18 months later you want to have the
15 contractor conduct the same task, then you -- you
16 just issue a new task. But you can't promise
17 future work in a task. Okay?

18 **MR. GRIFFON:** I -- yeah, if they want to look
19 at it -- I mean the intent there was that -- in
20 "may" -- we put "may" because you said -- that's
21 what we heard, that you can't promise future work
22 in the task.

23 **MR. ELLIOTT:** I think what procurement will
24 say is that that sentence needs to come out. But
25 we'll leave it up to procurement if --

1 **MR. GRIFFON:** As long as we've established --

2 **DR. ZIEMER:** In which case, the following
3 sentence would also come out because it explains
4 why the period --

5 **MR. ELLIOTT:** Right.

6 **DR. ZIEMER:** -- periodic review, so --

7 **MR. ELLIOTT:** Right, you can reissue a task
8 previously done --

9 **MR. GRIFFON:** Right.

10 **MR. ELLIOTT:** -- at any point in time, but
11 you can't promise future work.

12 **MR. GRIFFON:** Okay. That may come --

13 **MR. ELLIOTT:** It builds expectation --

14 **MR. GRIFFON:** That may come up in the next
15 one, too, so...

16 **DR. ZIEMER:** And I think, Mark, you're saying
17 the word -- the use of the word "may" doesn't
18 promise anything, but Larry's suggesting it may
19 nonetheless raise the --

20 **MR. GRIFFON:** Well, I --

21 **DR. ZIEMER:** -- anticipation level or --
22 yeah. Or it could be left out. It doesn't
23 change the immediate task.

24 **MR. GRIFFON:** I actually -- you know, it was
25 in the original task order contract, too, so I

1 don't know if we promised it in there. All this
2 language was lifted from that. And also for the
3 individual dose reconstruction reviews, it talked
4 about five years of reviews in the original
5 contract that we put out.

6 **MR. ELLIOTT:** But you're talking about RFP
7 versus an individual task.

8 **MR. GRIFFON:** All right, that's fine.

9 **MR. ELLIOTT:** And I think -- I think
10 procurement's going to say to us that each task
11 has to be a stand-alone and can't --

12 **MR. GRIFFON:** That's fine.

13 **MR. ELLIOTT:** -- can't indicate that there's
14 going to be, you know, follow-on work on that
15 same task. There's a discrete -- these are
16 discrete tasks with discrete deliverables,
17 discrete endpoints, and that's what they're going
18 to -- I'm pretty sure they're going to preach
19 that to us, so...

20 **MR. GRIFFON:** Yeah. I have no problem with
21 that coming out if it has to come out.

22 **DR. ZIEMER:** Any objection to deleting those
23 two sentences since there is no promise of future
24 extensions in any event? Without objection,
25 we'll just delete the second and third sentence

1 of that paragraph then. That's the sentences
2 that say "This task may be extended to be a
3 periodic annual review of procedures since it is
4 likely that procedures will be modified as the
5 program evolves. The focus of the periodic
6 reviews will be to assure overall consistency of
7 the program from the earliest cases that were
8 completed." Those two sentences would then be
9 deleted. Thank you.

10 Other comments?

11 (No responses)

12 Is the Board then ready to take action on
13 this statement?

14 (No responses)

15 It appears that we're ready to vote. I'll
16 ask that all who favor this -- the statement of
17 work as modified, please say aye.

18 (Affirmative responses)

19 Any opposed, say no.

20 (No responses)

21 Any abstentions?

22 (No responses)

23 The motion carries.

24 **MR. GRIFFON:** Okay. The second task order
25 there is the lengthier one on individual dose

1 reconstruction review. Again, I think -- just --
2 just to pick up on the point we just discussed,
3 in the third paragraph, the last sentence, I
4 guess we should delete the sentence starting "The
5 Board anticipates that the next four years will
6 also involve a review of 2.5 percent of the total
7 cases." Is that correct, Larry? I think that
8 has to come out -- those last two sentences, also
9 the sentence saying "For purposes of this
10 proposal the contractor should only consider the
11 first year workload." So those last two
12 sentences will be removed.

13 **MR. ELLIOTT:** Yes, I think that would be
14 advisable. And here again, just so it's on the
15 record here and I'm clearly not trying to drive
16 you one way or another, this -- this is -- on the
17 previous one, the word that bothered me was
18 "extended", not "may". You know, you can't --
19 it's got to be a discrete task, and you can just
20 reissue the task again once you have the
21 deliverables in your hand, and virtually have
22 them work the same task at a different time.

23 **MR. GRIFFON:** The only other thing I wanted
24 to note was on the last page -- really everything
25 in the middle is remain the same. The last page,

1 period of performance, is new. I'm sorry I
2 didn't leave these highlighted. I accepted the
3 changes. And reporting/deliverable requirements
4 is a new paragraph, as well. And I think in
5 there I reference this procedure that I gave to
6 everyone last night to look at, processing
7 individual dose reconstruction reviews. I was
8 going to give it a procedure number, but I think
9 we should just delete that at this point. We can
10 reference it by name.

11 **DR. ZIEMER:** Mark, are you suggesting that
12 where it says "Board number XX", that would just
13 be deleted from your document?

14 **MR. GRIFFON:** Yes. Yes.

15 **DR. ZIEMER:** In the very last paragraph.

16 **MR. GRIFFON:** Uh-huh.

17 **DR. ZIEMER:** It's just what would have been
18 an ID number. Right.

19 Okay. Questions or comments? Are you moving
20 adoption of this procedure -- or statement of
21 work?

22 **MR. GRIFFON:** Yeah, I think the working group
23 would make a motion to --

24 **DR. ZIEMER:** On behalf of --

25 **MR. GRIFFON:** -- to accept this --

1 **DR. DEHART:** Mark, isn't it correct that it's
2 only in the advanced review, which is on page 3,
3 advanced review --

4 **DR. ZIEMER:** Use your mike there, Roy, if you
5 would, please.

6 **DR. DEHART:** My question addresses the
7 advanced review. It is in this document item 2,
8 page 3, that we first do the site profile. Is
9 that correct? That the basic does not do a site
10 profile, but this -- at this level, we do.

11 **MR. GRIFFON:** Yes, in the -- yes, this -- the
12 advanced looks at is the dose reconstruction
13 consistent with the site profile, so it sort of
14 ties those two together, right. The basic does
15 not go to that depth, that's correct.

16 **DR. ZIEMER:** Tony, another question or -- no?
17 Okay.

18 **DR. ANDRADE:** Paul --

19 **DR. ZIEMER:** Yes, Tony.

20 **DR. ANDRADE:** Perhaps I do have a question.
21 With respect to the advanced review, on item B,
22 item 1 under B, it says "Evaluate the
23 effectiveness of the phone interview". As you
24 said, it really doesn't go into the specifics of
25 the procedure for doing so. However, this is

1 kind of an -- what I would say an open-ended work
2 statement that's going to -- it's going to
3 require or probably going to get -- likelihood is
4 that the contractor will come back with a
5 question as to what -- a clarification of
6 effectiveness is, and I think we're going to get
7 back into the same discussion that we were
8 engaged in yesterday. So I just wanted to note
9 my concern with respect to this particular item
10 on the SOW.

11 **DR. ZIEMER:** Mark, do you want to respond to
12 that?

13 **MR. GRIFFON:** I mean just that it wouldn't
14 allow for the re-interviewing. They can do --
15 they are required to evaluate the effectiveness
16 of it based on the documented phone interview
17 form, and that -- that's where it stops. They're
18 not allowed -- under this task they're not --
19 they don't have the option of re-interviewing any
20 claimant. So you know, they -- they may have
21 some questions on what "effectiveness" means, but
22 you know, the option of re-interviewing is not
23 opened up there.

24 **DR. ZIEMER:** Tony, are you okay on that or
25 you feel it lacks clarity or...

1 **DR. ANDRADE:** No, I'm satisfied with the
2 response. I do have a feeling we are going to be
3 handed requests for clarification, but that's
4 really the only point I had to make.

5 **DR. ZIEMER:** Okay. Roy DeHart.

6 **DR. DEHART:** There is one other way of
7 looking at the effectiveness. That is if the
8 interviewee responds, after reviewing what has
9 been documented from that interview, with a lot
10 of additional comments, and we see that
11 repeatedly, then something's faulty with the
12 interview process. So there's ways of looking at
13 that.

14 **DR. ZIEMER:** Jim?

15 **DR. MELIUS:** Another separate question.
16 Regards the -- that -- the previous question
17 about site profile and the site profile only
18 coming up in the advanced review, did the task
19 group think -- I guess -- didn't really hear
20 about this in detail till after you met this
21 morning. Given that it appears that the site
22 profiles have become a sort of a basic procedural
23 document that are going to be used in all of --
24 nearly all of the dose reconstructions, shouldn't
25 -- don't -- should we include that in the basic

1 review, I guess is my question, since it's going
2 to be central to so many -- right now we sort of
3 evaluated against the procedures and other
4 procedures and so forth. To me, the site profile
5 is described -- has almost become a -- you know,
6 a standard procedure and that we ought to be
7 evaluating it and I think it would be relatively
8 straightforward to do that. I just can't see how
9 the -- how you can avoid doing it.

10 **MR. GRIFFON:** Yeah, I actually -- now that --
11 I actually think it's going to happen, you know.
12 I mean if -- if the site profile is working the
13 way we see the efficiency process working and
14 things like that, it's probably going to be
15 referenced in the bas-- in all the -- you know,
16 in all the dose reconstructions. And I guess --
17 yeah, and we didn't know of this until, you know
18 -- so this is kind of new for us. But the other
19 thing is that for the -- for a more extensive
20 site profile review, we're going to have a
21 separate task, too. So we do have the chance to
22 review the site profile as a separate entity.

23 **DR. ZIEMER:** I might add a comment here, too,
24 Jim. I think that item A.2 of the basic review
25 opens the door for including the site profiles

1 insofar as it tells the reviewer to review the
2 data used by NIOSH for that case. And indeed if
3 site profile was part of that, I think the door
4 is open for -- I don't think it's excluded, is
5 what I'm saying.

6 **DR. MELIUS:** Yeah, I think it actually fits
7 under several of these --

8 **DR. ZIEMER:** Yes, right.

9 **DR. MELIUS:** -- as I'm reading through, and I
10 guess --

11 **DR. ZIEMER:** It's not called out
12 specifically, but it certainly is -- if it's been
13 used, it's there.

14 **DR. MELIUS:** Yeah, okay. Right.

15 **DR. ZIEMER:** Yes, Larry.

16 **MR. ELLIOTT:** If I might make a suggestion on
17 page 4, item 3, blind dose reconstruction, I
18 think it would be beneficial if you would specify
19 who's going to select those ten. I know it's
20 implicit in page 1 down at the bottom there,
21 first -- or the last paragraph of page 1, but I -
22 - it -- I think it should be clear that the Board
23 is going to make those selections, not your
24 contractor. You're going to -- somebody's going
25 to have to create these ten case files that are

1 blind, and you don't want your contractor doing
2 that, I'm sure. And we're not going to do that,
3 I'm sure. See what I'm after?

4 **DR. ZIEMER:** You're talking about item 3 on
5 the last page, I believe.

6 **MR. ELLIOTT:** Item 3, page 4, blind dose
7 reconstruction. In that two or three-sentence
8 paragraph, I think you should be explicit as to
9 who makes those -- who selects those and prepares
10 them.

11 **MR. GRIFFON:** And it's not -- I mean we say
12 it up front, but you say we should restate it
13 especially for the blind -- the preparation of
14 the cases, as well.

15 **MR. ELLIOTT:** Well, I think it --

16 **MR. GRIFFON:** Not only -- not only selection,
17 but preparation of the...

18 **MR. ELLIOTT:** I don't see it explicit up
19 front. I think it's implicit up front that the
20 Board is going to do it, but I -- you know.

21 **MR. GRIFFON:** Maybe it doesn't, okay.

22 **DR. ZIEMER:** Mark, I believe that certainly
23 was your intent.

24 **MR. GRIFFON:** Yes.

25 **DR. ZIEMER:** If it's not explicit here,

1 perhaps a sentence could be added --

2 **MR. GRIFFON:** Yeah, I think --

3 **DR. ZIEMER:** -- to that.

4 **MR. GRIFFON:** -- we should add it, yeah.

5 **DR. ZIEMER:** Could we --

6 **MR. GRIFFON:** I thought it was up front.

7 **DR. ZIEMER:** Yeah.

8 **MR. GRIFFON:** Re-reading...

9 **DR. ZIEMER:** Could we simply agree that an
10 appropriate explicit sentence would be added? I
11 don't know if it's to be up front or there. And
12 while you're thinking about that, Wanda, you have
13 another item?

14 **MS. MUNN:** Yes, I might address that one, as
15 well. Wouldn't it probably be cleaner to just
16 put it up front on the first page and say ten
17 blind review cases, specifically chosen by the
18 Board?

19 **MR. GRIFFON:** Actually even further than
20 that, I would say why don't we just add a
21 sentence at the end of that third paragraph on
22 the first page saying that the Board shall select
23 all cases for review, period. And that makes it
24 clear that the contractor's not.

25 **MS. MUNN:** All right.

1 **DR. ZIEMER:** Is that agreeable? You're
2 adding that at the first paragraph on page 1?

3 **MR. GRIFFON:** Bottom of the third paragraph
4 on page 1, yes.

5 **DR. ZIEMER:** Give us the wording on that
6 again, Mark.

7 **MR. GRIFFON:** The Board shall select all
8 cases for review.

9 **MS. MUNN:** For this review or these reviews?

10 **DR. ZIEMER:** Okay? Wanda, do you want to
11 continue? Without objection, we're making that
12 modification. Okay.

13 You had another item then?

14 **MS. MUNN:** Yes. Originally I was back on
15 page 3, B.1 again, the concern that had been
16 expressed earlier with respect to what do we mean
17 by "effectiveness" and where we can go from
18 there. I might suggest a slight wording change
19 so that it would read -- since we can't expect
20 this contractor I think to actually verify
21 effectiveness, I don't know how you'd do that.
22 Perhaps evaluate the completeness of the phone
23 interview and ascertaining that all relevant work
24 history information has been addressed. That's
25 really the best they can do, isn't it, to make

1 sure they cover the waterfront?

2 **DR. ZIEMER:** I suspect we're all a little
3 fuzzy on that. I'm not sure we know whether they
4 can evaluate the completeness, either. What -- I
5 guess it would come down to what do you mean by
6 the completeness of the phone interview.

7 **MS. MUNN:** We have the form identified. The
8 form is as complete as we can get it, in terms of
9 this is the material that needs to be covered
10 when you interview these folks. Now is the
11 material that's on the form that we've agreed is
12 going to be used adequately represented in the
13 report that NIOSH is submitting as its report of
14 this interview.

15 **DR. ZIEMER:** Well, anyone want to respond?
16 It's -- maybe we need both words, "effectiveness"
17 and "completeness". Or maybe we just need
18 "evaluate the phone interview".

19 **DR. MELIUS:** I was going to say maybe we can
20 qualify it better by saying "based on the
21 available record of the phone interview and other
22 information in the case record, evaluate the
23 phone interview in ascertaining relevant work
24 history information". I think we -- I think if
25 we limit the -- what they're directed at rather

1 than trying to describe the evaluation, I think -
2 - I think it's easier.

3 **DR. ZIEMER:** What Jim is suggesting, I
4 believe, is that it would say "evaluate the phone
5 interview in ascertaining relevant work history
6 information".

7 **DR. MELIUS:** Based on --

8 **DR. ZIEMER:** Do you want to add any
9 qualifiers or is that --

10 **DR. MELIUS:** The qualifier I would add is
11 "based on the -- the record -- record of the --
12 available record of the phone interview and other
13 information in the case record" -- 'cause they
14 would use other information from the case record,
15 so it's still a records-based review.

16 **DR. ZIEMER:** Without using words like
17 "completeness" or "effectiveness" or --

18 **DR. MELIUS:** Completeness, right, or...

19 **DR. ZIEMER:** -- which may have specific
20 meanings.

21 **DR. MELIUS:** And we're directing them at the
22 ascertaining the relevant work history
23 information. That evaluation can include various
24 components, but I think if we circumscribe it to
25 just what's available in the record, I think

1 we...

2 **MS. MUNN:** Then can we just simply say
3 "Evaluate the phone interview to ascertain that
4 all relevant work history information has been
5 addressed"? The simpler the better, I think.

6 **DR. ZIEMER:** Yes, that's a possibility.
7 Tony?

8 **DR. ANDRADE:** As you'll probably see
9 tomorrow, you'll gather bits and pieces in
10 certain interviews, and especially when it's
11 survivors that are being interviewed. There may
12 be very little that has to do with the actual
13 claimant's work history. And so there's not
14 really going to be a validation or a vetting of
15 information in many instances on what the
16 interview -- what came out of the interview
17 versus other data that may be available, such as
18 a site profile.

19 **MR. GRIFFON:** Yeah, we do address the
20 survivor issue, as well, in the second bullet in
21 B, yeah. But I mean I think -- I think -- well,
22 actually I think the simpler the better. I'm not
23 sure I have a problem with the original language,
24 but if we have to say "evaluate the phone
25 interview in ascertaining relevant work history

1 information based on the phone interview record,
2 along with the relevant documents within the
3 administrative record", I think that'd be fine.

4 **DR. ZIEMER:** Well, I guess I would even
5 question whether we need all that -- how are you
6 going to evaluate the phone interview record if
7 you don't use the phone interview record? I mean
8 why do we have to say based on the phone
9 interview record?

10 **MR. GRIFFON:** I agree, you can stop --

11 **DR. MELIUS:** I think we're -- we started this
12 out by questioning whether what -- a scope of
13 what we were doing, and so it -- try -- one issue
14 to try to circumscribe the scope, make sure that
15 it is on the record, and the second issue, which
16 is Wanda's, exactly what does the evaluation
17 entail.

18 **DR. ZIEMER:** Well, you know, in these other
19 evaluations, we're not spelling out in detail how
20 they're to be done. Part of what the
21 contractor's job is going to be is to develop
22 evaluation tools. Right? So why not let them do
23 that here, also? Eventually we will have to
24 approve those tools.

25 **MR. GRIFFON:** Yeah, the -- and I think your

1 -- Paul, your suggestion, "evaluate the phone
2 interview", drop out "effectiveness of the".

3 **DR. ZIEMER:** Yeah, "evaluate the phone
4 interview in ascertaining relevant work history
5 information", boom.

6 **MR. GRIFFON:** Leave it at that, yeah.

7 **DR. ZIEMER:** Anyone object to the -- keep it
8 simple, as someone has suggested -- Wanda, I
9 guess -- and -- I mean we've not tried to tell
10 the contractor here how to develop all these
11 tools in the other stuff, so -- okay. Is that
12 agreeable?

13 (No responses)

14 Okay. So without objection, we will just
15 delete the words "the effectiveness of".

16 Now, are we making progress? Yes. Other
17 items?

18 (No responses)

19 Are we ready to take action?

20 (No responses)

21 It appears we may be ready to act on the
22 motion to approve the statement of work for
23 individual dose reconstruction reviews, with the
24 two minor modifications that -- one of which was
25 part of the original motion, the change in the

1 last two sentences on page 1, and then this minor
2 change on the phone interview statement.

3 Okay. All who favor then this statement of
4 work -- oh, I'm sorry. Mike.

5 **MR. GIBSON:** We'd had some discussion earlier
6 on about the advanced review of the site
7 evaluations documents really wouldn't be an
8 advanced review, it'd be part of the process. Is
9 there -- do we want to delete "advanced review"
10 and add that into the basic scope on page 3, or
11 are we just considering the fact that that goes
12 along without saying?

13 **DR. ZIEMER:** Let me try to answer that, and
14 then maybe Mark can clarify. I think the
15 original question that was raised was sort of
16 along the lines of does the basic review exclude
17 site profiles, something like that. And I think
18 we agreed the answer was no, not necessarily. If
19 site profiles were used in those dose
20 reconstructions, that's open game for that
21 review. The advanced review is more specific in
22 calling for that site profile review, partially
23 because the advanced review in many ways is
24 looking at the administrative record in more
25 detail than the basics. But I think we believe

1 that it's not excluded. Is that -- yeah. Are
2 you okay on that, Mike?

3 **MR. GIBSON:** Yeah, I just wanted to make sure
4 we're --

5 **DR. ZIEMER:** Yeah, right. Right. Okay. Now
6 are we ready to vote then?

7 (No responses)

8 I think we are. All who favor the motion to
9 approve this statement of work on individual dose
10 reconstruction reviews, please say aye.

11 (Affirmative responses)

12 Any opposed say no.

13 (No responses)

14 And any abstentions?

15 (No responses)

16 Motion carries. Thank you very much.

17 Does the working group have any other items?

18 **MR. GRIFFON:** Yes.

19 **DR. ZIEMER:** Thank you. Please proceed.

20 **MR. GRIFFON:** Okay. The next item is really
21 a discussion item following up from yesterday's
22 discussion. And we -- this morning in our
23 working group meeting we asked NIOSH some
24 questions on the contracting process, and I had -
25 - now that we have two tasks approved, this is --

1 you know, obviously we have to push these
2 forward. Larry answered one question, which is
3 that once the tasks are released to the
4 contractors, they'll probably have about two
5 weeks to respond -- didn't you say -- I'm not
6 trying to put words in your mouth.

7 Then the question, I guess -- we had some
8 questions, which I'm not sure if they were
9 procurement questions or FACA questions, I think
10 a little bit of both. What steps would be
11 involved from there on out and what would be the
12 time frame. And I think a discussion that we
13 have, which we couldn't really answer this
14 morning, was would the entire Board have to act
15 on any meetings with the contractor to resolve
16 scope or -- or to approve the task to move
17 forward, could a subcommittee take that role.
18 And then further, could those -- would those
19 discussions require executive session. And so we
20 had some of those issues that we just didn't have
21 answers to but we think we need to raise them and
22 get answers fairly quickly so we can move ahead.

23 You have the answers?

24 **MR. ELLIOTT:** Okay. Well, I don't have the
25 answers, but we certainly captured, I believe,

1 between general counsel and staff this morning
2 that sat with you, the list of questions you
3 raised and we'll be pursuing the answers for
4 those very expeditiously.

5 **MR. GRIFFON:** I think what -- what we also
6 talked about this morning in our working group
7 was that we as a working group probably -- may
8 want to consider a meeting in Cincinnati, maybe
9 at -- for -- it probably wouldn't -- I mean if we
10 have one day to dedicate to this, we could iron
11 through the rest of -- some of this stuff and
12 then report back to the full Board and have, you
13 know, more final tasks like this to move through,
14 and also a clearer understanding of the process.

15 **MR. ELLIOTT:** Sure.

16 **MR. GRIFFON:** I think that'd be a worthwhile
17 endeavor.

18 **MR. ELLIOTT:** We'll certainly support that
19 and assist you in scheduling it. I also would --
20 not to steer you in another direction, but I do
21 think it would be beneficial for you to come
22 forward with the task that speaks to the tracking
23 of your cases, but also this -- you know, I
24 hadn't thought of it until Dr. Ziemer mentioned
25 it, but the tools that you're going to --

1 evidently you want to review the tools and
2 approve the tools that are going to be used by
3 your contractor. And you may want to wrap that
4 up into one task, the tracking task, perhaps. I
5 don't know if it makes sense to do that or if you
6 need two tasks, but you're going to have to
7 specify at some point in time that you want to
8 see the tools and you want to approve the tools
9 and what those tools are to be, so maybe -- maybe
10 a full day --

11 **MR. GRIFFON:** Yeah, we -- we --

12 **MR. ELLIOTT:** -- you could get to all of
13 that, I don't know, but --

14 **MR. GRIFFON:** Yeah, we -- I did take a stab
15 at an initial case tracking task, but in -- we
16 didn't even have time to discuss it in our
17 morning working group session. And part of what
18 I was thinking was the case -- the case tracking
19 task was going to do was I envisioned that -- and
20 I was looking at this along with the question of
21 case selection, and thought that a reasonable
22 task to ask the contractor to do up front would
23 be to work with NIOSH and establish a baseline
24 matrix of all the cases and laying out all the
25 parameters of interest for us -- the Board. Then

1 once we have the baseline matrix, then we have
2 something to sample from, to get our cases from.
3 And some of these things -- in informal
4 discussions I've noticed that some of these
5 things may not be simply there to pull off the
6 database -- there may be a little work involved
7 to get some of the parameters. You know, one
8 parameter we're considering is job group or first
9 decade employed is some other parameters we've
10 thrown out. So it may not be just something that
11 they can simply pull -- you know, so that would
12 be a sub-task for the contractor to develop would
13 be this matrix of cases versus -- versus the
14 various parameters, including site and all those
15 parameters we've discussed in the past.

16 **MR. ELLIOTT:** Did you also have a discussion
17 about the process of review itself? We need to
18 get a sense of how you see that running. And
19 maybe Jim's got this from your discussion, I
20 don't know. But you talk in the task orders
21 about selected Board members working with the
22 contractor in the review. Have you had
23 discussion about how that'll work and can you
24 share that with --

25 **MR. GRIFFON:** Yeah, we -- the procedure that

1 we passed around last night was the first stab at
2 sort of outlining how that process is going to
3 work. You know, I think we -- we had further
4 discussions on that this morning involving the
5 question of -- of reports back to the full Board
6 and what they're -- you know, how we have to be
7 careful of Privacy Act issues on those public
8 reports. So that is -- and we could do that
9 next. I think we should do that next, you know,
10 but we did discuss that this morning.

11 **DR. ZIEMER:** Mark, I also want to make sure
12 that the Board goes into this with eyes open. If
13 you look at -- look at the last paragraph of what
14 you just approved on deliverables, and the -- 25
15 cases every two months is mentioned in here. I
16 looked at this in terms of Board panels. For
17 example, if we had three Board members per panel
18 plus a contractor, let's say, but -- and I don't
19 know what you're thinking in the working group,
20 but as an example, then each panel would have say
21 six cases every two months or about three cases
22 per month to review in detail. That would be
23 each Board member, four panels of three, for
24 example.

25 Or if you wanted a lighter load, you might

1 have two Board members per panel with a
2 contractor. That means each panel would have
3 about four cases per month -- or per two months,
4 or about two cases per month, every Board member,
5 to review in detail. This is not a trivial task,
6 so what --

7 **MR. GRIFFON:** No, and it's good to point that
8 out. I mean it's not a trivial task, it's --

9 **DR. ZIEMER:** What were --

10 **MR. GRIFFON:** -- it also is --

11 **DR. ZIEMER:** What was the working --

12 **MR. GRIFFON:** We're signing off --

13 **DR. ZIEMER:** -- group thinking about?

14 **MR. GRIFFON:** -- on these, you know, so --

15 **DR. ZIEMER:** The bigger the panel, the bigger
16 your workload. If you spread it out to smaller -
17 - like two Board members per panel -- then you
18 lighten your workload.

19 **MR. GRIFFON:** Yeah, I mean we -- we can move
20 to that procedure. It does suggest --

21 **DR. ZIEMER:** It's open-ended --

22 **MR. GRIFFON:** -- two.

23 **DR. ZIEMER:** -- right now.

24 **MR. GRIFFON:** It does suggest two people per
25 -- it does suggest --

1 **DR. ZIEMER:** Right.

2 **MR. GRIFFON:** -- I think two members.

3 **DR. ZIEMER:** Right. Which I think gives you
4 about two cases per month that you would be
5 personally responsible for. Is that -- was that
6 your thinking? That's how it calculates out, as
7 far as I could see. Okay.

8 Tony, you had a comment or question and you
9 got cut off there, I think. Or did you?

10 **DR. ANDRADE:** Well, we were I think just
11 about to start discussing the process for case
12 selection, and I think we're -- we were focusing
13 in on the -- on the idea of developing a matrix
14 that would list the types of cases, basically,
15 that the contractor would be reviewing. I was
16 just going to suggest that, number one, I think
17 that a rough matrix has already been developed
18 and I think Mark actually took a stab at that.
19 And indeed, given the dose reconstructions that
20 have taken place to date, you're not going to be
21 able to fill out that matrix in a way that really
22 starts to populate all of the areas. So I think
23 that -- in my judgment or in my opinion, in any
24 case -- it would perhaps be best to develop this
25 task, because we don't have to issue all the

1 tasks at once, but develop this task over time,
2 perhaps developing this to a point where it can
3 really be released to the contractor, by the end
4 of the year when we expect to see several
5 facilities and site profiles developed and
6 thereby different types of dose reconstructions
7 done. So all I'm asking is that -- or what I'm
8 suggesting for consideration is that we might
9 think about this, defer discussion and develop
10 this task for issuance at a later date.

11 **MR. GRIFFON:** Can I take a stab at -- let me
12 just take a stab at first explaining the -- the
13 matrix I'm describing would be -- it wouldn't --
14 there's two parts that I was suggesting, this
15 tracking and -- if it wasn't so raw I'd discuss
16 it here, but I didn't even circulate it to the
17 working group. Two parts, one would be develop
18 the matrix on the existing cases that -- that are
19 in NIOSH's system. And that doesn't mean just
20 approved cases, but all -- all the ones in the
21 hopper, sort of. And then the idea -- then the
22 second part of the contractor's requirement will
23 be to track -- so that -- and the intent here was
24 that we may have 300 or so coming from Savannah
25 River up front, and they may be the only ones in

1 there. But we don't want to -- you know, we may
2 only want to sample certain ones of those, so
3 we'll only fill certain fields. And we may have
4 to slow down our review until we get other types
5 of cases. We don't want to over-populate in one
6 field or another. But I think it would be useful
7 up front to get a snapshot of what types of cases
8 are out there, and then we can refine our
9 stratified sampling strategy based on what -- you
10 know, what -- what the matrix looks like, the up
11 front 6,000 or so cases in the system look like.
12 So that -- that -- it's kind of two levels of
13 that. And I thought they'd do the up front part
14 initially. And this tracking task is not ready
15 to -- you know, for the Board's approval now
16 anyway, so it would -- it would wait a little
17 here.

18 **DR. MELIUS:** Yeah.

19 **DR. ZIEMER:** Jim and then Roy.

20 **DR. MELIUS:** Mark and I talked about this a
21 bit last night, so -- the only place I'd differ
22 with what Tony was saying was I think that --
23 it's not clear to me from looking at the database
24 getting my training yesterday morning that all
25 the elements that we may want to select on or

1 track on are readily available for selection.
2 And I think that -- I don't think -- I agree with
3 Tony, we're not going to be able to select until
4 the end of the year and we have everything -- you
5 know, enough cases completed out there to do
6 that. And I think Mark's right, given the way
7 they're being done in batches, it's not going to
8 be -- you know, we were sort of assuming it'd be
9 sort of a random group to be selecting from.
10 They're not. They're going to be done in batches
11 and so that's going to complicate things even
12 further.

13 However, I think we may want to consider
14 either one of two things. Either one is an early
15 task for the contractor to go out and examine the
16 database, work with NIOSH and see how certain
17 information is available, what would be feasible
18 and easy to select on when we're choosing cases -
19 - you know, what would be potential procedures,
20 so we don't develop a selection procedure that is
21 going to be very burdensome for -- to do, or
22 impossible. Or the alternative to that is the
23 task group, when you're meeting, if you have
24 time, is to do that 'cause I don't think it's
25 that complicated 'cause it's so much looking at

1 the database structure, but -- seeing how it
2 might be done. But either one of those I think
3 would be helpful to do before the end of the year
4 so that when the end of the year we can then more
5 fully develop a way of selecting the cases. But
6 a lot of the information we want is contained in
7 documents within the database, so it's not easy -
8 - necessarily easy to select from. There's also
9 problems with people with more than one type of
10 cancer and people that worked at multiple
11 facilities that complicate the -- some of these -
12 - these issues. So you know, selecting someone
13 from Savannah River or whatever may not be as
14 easy as it may seem. And that may vary depending
15 on the site and so forth, so I think either of
16 those alternatives ought to be looked into. I
17 don't know whether we need to do it today or when
18 the work group meets, but I think it might be
19 helpful before we get going.

20 **DR. ZIEMER:** Roy and then Larry.

21 **DR. DEHART:** Trying to get a handle on when
22 the reality of having cases available for us
23 specifically to review, I think we need to
24 remember that these cases are cases that have
25 been finalized. I'm not sure whether that means

1 finalized by Congress. Don't they have a period
2 of time to review, as well?

3 **MR. ELLIOTT:** Congress?

4 **DR. ZIEMER:** The cases may have a period of
5 time for appealing and there may be an issue
6 there.

7 **DR. DEHART:** Somebody reviews --

8 **DR. ZIEMER:** Is there --

9 **DR. DEHART:** -- this case beyond us.

10 **DR. ZIEMER:** Is there an appeal period after
11 adjudication?

12 **DR. DEHART:** So it --

13 **DR. ZIEMER:** Sixty days after?

14 **MR. ELLIOTT:** They can get actually to 60
15 days.

16 **DR. DEHART:** Yes.

17 **MR. ELLIOTT:** But it's not -- Congress is not
18 involved in this. You're confusing it with the
19 SEC process --

20 **DR. DEHART:** Yes.

21 **MR. ELLIOTT:** -- I think.

22 **DR. DEHART:** So when would we anticipate
23 having cases ready to review then, for us, that
24 have gone through everything and the decision has
25 been made? First of the year, or is it even

1 going into the winter?

2 **MR. ELLIOTT:** We're looking into that,
3 because there --

4 **DR. ANDERSON:** First of the year is winter,
5 for many of us not from Tennessee.

6 **MR. ELLIOTT:** Recall that you're to re-- your
7 audit is to look at final adjudicated cases.

8 **DR. DEHART:** Right.

9 **MR. ELLIOTT:** Those that have achieved that
10 final status where either they've been deemed
11 compensable or non-compensable. And if they're
12 non-compensable, there's no -- evidently they're
13 -- you know, they're not in an appeal stage. If
14 they're in an appeal stage, that's still tied up.

15 **DR. DEHART:** That's correct.

16 **MR. ELLIOTT:** And there's -- there's some
17 issues associated with -- I'm just blanking on
18 the terminology, help me out here.

19 **MR. NAIMON:** Challenges in court?

20 **MR. ELLIOTT:** Well, challenges in court, but
21 there's the life of the claim, until it's no
22 longer -- what's --

23 **MR. NAIMON:** Statute of limitations.

24 **MR. ELLIOTT:** Statute of limitations on the
25 claim, which is much too long, as we know it to

1 be. Six years is too long for you to wait.
2 Okay? So we've got to do a little homework and
3 we've got to coordinate with the Department of
4 Labor on this as to when a case has achieved a
5 point of adjudication that can be audited. Okay?
6 So we're working that issue. I don't know if
7 that answers your question clearly or
8 confusingly, but we don't have a final answer
9 yet. We're working --

10 **DR. DEHART:** It sounds like that we have
11 several months yet to -- before there's an issue
12 for us to --

13 **MR. ELLIOTT:** Well, certainly we don't
14 anticipate compensable cases to be contested, and
15 so there are a number of -- you know, right now
16 we're -- I think we're around 45 to 47 percent
17 compensable in the number we have done. That
18 doesn't mean all those have reached that final
19 adjudication point. There's some of those still
20 in recommended decision. But by the end of the
21 year, yes, I think you'll have a goodly number to
22 look at.

23 **DR. DEHART:** Thank you.

24 **MR. ELLIOTT:** I would also like to comment
25 back on something Mark said a minute ago that --

1 what's in the hopper, not what's final, not --
2 you know, let's take the number 13,500 that's in
3 the hopper right now to be done and -- to put a
4 matrix together. I don't believe that is your
5 contractor's work. That is our job. I think
6 that we have a robust data tracking system. Yes,
7 it does not right now drill down to some of the
8 things you want, and Dr. Melius knows this from
9 his training yesterday morning. This was a topic
10 of discussion we briefly had that right now we
11 can't produce a report from that system that says
12 how many lung cancer cases do we have for a given
13 site. I think -- well, we might be able to do
14 that, but it'll -- it takes a little bit of labor
15 right now, we -- so what I'm proposing is that
16 you come to grips with what you're matrix is
17 going to contain and tell us what those
18 parameters are that you want to see populated
19 eventually of what's in the hopper, and we'll
20 have our IT staff work to put that into place.

21 **DR. ZIEMER:** Thank you. Other comments?

22 **DR. MELIUS:** Yeah.

23 **DR. ZIEMER:** Jim.

24 **DR. MELIUS:** I'll just follow up on that. I
25 appreciate your offer to sort of change your

1 database for our purposes, but I think it would
2 still work better if it were a little bit more of
3 an interactive process 'cause it may very well be
4 possible to select cases based on things that are
5 already in the database and not make extra work
6 for you in order to do that. At the same time, I
7 think if we did it sort of jointly in some way
8 rather -- that's -- may be things that would
9 serve your purposes, also. And it may turn out
10 that all these things would be helpful for you,
11 too, to have information on, so I still think we
12 should try to work together on it and coordinate
13 what we're -- what we're doing in that regard.

14 In regard to Roy's comment and so forth, I --
15 we're going -- the work group may need to spend
16 some time on this, but I'm not sure we have to
17 wait until we get to 3,000 or 4,000 or whatever,
18 certainly for some of the early reviews and so
19 forth that -- you know, it may be a number
20 shorter than that that we're going to feel
21 comfortable sampling from. I think all of us
22 know that right now if we sampled randomly we'd
23 see a lot of Bethlehem Steel. And you know,
24 maybe it'll be -- next a lot of Savannah River
25 with Bethlehem Steel or whatever. But I still

1 think there may be enough to certainly start a
2 review process short of having -- you know, maybe
3 it's a very small sample we'll take from that,
4 but I think we can get it going and I'm not -- I
5 worry that, given all the procurement and other
6 bureaucratic hurdles we have ahead of us that --
7 I don't think we should count on we don't have to
8 do anything till next April, and I don't think
9 that's what you were suggesting, but that we, you
10 know, recognize that it -- we get the process
11 going and get things in place, it'll be easier.

12 **DR. ZIEMER:** Henry.

13 **DR. ANDERSON:** Yeah, I would suggest we have
14 a pilot phase and then we'll have a production
15 phase. In the pilot phase we don't need to worry
16 quite so much about the rigorous sampling
17 framework. I think with what we have, we ought
18 to get started as soon as we get the contractor
19 going and get some sense of --

20 **DR. ZIEMER:** Right, some experience.

21 **DR. ANDERSON:** -- how we're going to do this
22 and what are the issues, because -- rather than
23 to try to spend a whole lot of up-front time
24 finalizing something that, once we start it, say
25 that this is unworkable. And then you're -- so

1 let's start with some -- we may want to do a
2 batch of 25 or so and then have a month or two
3 delay while we process those.

4 **DR. ZIEMER:** Yeah, or even less. And I
5 think, Jim, what you were suggesting sounds very
6 much like a pilot program, anyway. Yeah. Other
7 comments?

8 **MR. GRIFFON:** Just to go back to that -- the
9 matr-- I mean we do have some draft parameters,
10 but I agree with Jim that when -- I would
11 volunteer the working group to come out soon, and
12 that could be one of the issues that we can take
13 up when we're sitting in front of the database
14 and thinking about this. You know, some
15 parameters -- it may get us to the same place,
16 I'm not sure, and if they're very difficult to
17 sort on, we could probably not -- necessarily
18 need to use, you know, those. So I think it
19 could be an interactive process.

20 **DR. ZIEMER:** Okay. Henry, did you put your
21 flag back up or is that --

22 **DR. ANDERSON:** No.

23 **DR. ZIEMER:** -- just left over? Okay. Mark,
24 do you have other items then from the working
25 group to --

1 **MR. GRIFFON:** Yeah, just to -- I think we've
2 sort of danced around it a little already, but
3 the procedure that went around last night, I
4 think it would be worthwhile to step through
5 that. This is the three -- three-page procedure
6 for processing individual dose reconstruction
7 reviews, which touches on some of the things
8 we've been talking about already, but --

9 **DR. ZIEMER:** Do you have extra copies of
10 that?

11 **MR. GRIFFON:** No.

12 **DR. ZIEMER:** I had it 'cause I wrote my
13 comments on it -- that's all right. Does
14 everyone have a copy?

15 **MR. GRIFFON:** I can -- I can call out some
16 things from our discussion this morning that --
17 you know, just --

18 **DR. ZIEMER:** Sure.

19 **MR. GRIFFON:** And then give you more time to
20 read through it, but we -- if you look down at
21 the fourth bullet there, interface of Board and
22 contractors with relevant experts -- and I think
23 it goes on to say and individ-- or individual
24 claimants. I have a modified draft, so -- and
25 that interface with individual claimants, I think

1 that is something that -- that's still -- you
2 know, needs to be discussed and maybe it can be
3 deleted from this process and handled separately
4 and, you know -- so just to highlight you on
5 that, that's that re-interviewing question that
6 we have. If you --

7 **DR. ZIEMER:** Did you say in your current
8 version you've actually deleted the individual
9 claimant state--

10 **MR. GRIFFON:** I've highlighted it.

11 **DR. ZIEMER:** Oh, highlighted --

12 **MR. GRIFFON:** I think from this process we
13 may, you know -- depending on how we want to
14 handle that -- that whole question, it may not be
15 part of -- you know, it's not part of the dose
16 review process right now, and this ties into the
17 dose review process.

18 **DR. ZIEMER:** Right.

19 **MR. GRIFFON:** So maybe it needs to be
20 deleted, yeah. Yeah. In section B we had a
21 fairly lengthy discussion on this. This brings
22 up the 25 cases every two months. I thought it
23 did say two, but apparently it does not say two
24 rotating members. It just says --

25 **DR. ZIEMER:** There was no number there.

1 **MR. GRIFFON:** Right.

2 **DR. ZIEMER:** That's why I was trying
3 different combinations.

4 **MR. GRIFFON:** I guess it was in other
5 discussions that we said two, but -- I added on a
6 few sentences under this about some items that we
7 brought up in our working group discussion this
8 morning. One is that the Board needs a conflict
9 of interest plan related to our review work. And
10 the second thing was -- oh, that -- the second
11 thing was that -- this was the questions of the
12 privacy thing and the idea that these rotating
13 members could work with the contractor and have
14 in-depth discussions about individual cases. But
15 in the -- in the summary report that came to the
16 full Board meeting, we would have the -- Privacy
17 Act rules had to be adhered to and therefore
18 you'd only be presenting summary information and
19 nothing that could reveal the identity of an
20 individual claimant. So we highlighted that in
21 that section just to make sure.

22 We put -- we talked about a potential that if
23 -- you know, we said that it may go down this
24 path where other Board members that weren't the
25 designated two or three may start questioning,

1 and they may want more information about
2 individual cases, and we started discussing the
3 notion of, you know, would it be possible to go
4 into executive session for the full Board to
5 discuss individual cases where privacy -- you
6 know, where you were potentially talking about
7 identifiable information. So that -- that -- it
8 was sort of those items was the potential that we
9 could go into executive session to discuss
10 individual cases, as -- as -- as deemed necessary
11 by the Board. But generally the idea was that
12 the in-depth discussion would be between the
13 designated members for those cases and the
14 contractor. Then the summary report that came to
15 the full Board would be Privacy Act -- you know,
16 would only be general summary findings. It would
17 not reveal any privacy information.

18 **DR. ZIEMER:** Comment on that by Larry.

19 **MR. ELLIOTT:** Yes, I would like to comment on
20 that, just for your edification. It certainly
21 could happen that way, but to go into executive
22 session you'd have to have it announced in
23 advance. Certainly any Board member that wanted
24 to see any individual claimant's administrative
25 record, we could accommodate that, you know,

1 separately from the Board meeting. But to go
2 into executive session, there's -- we have to get
3 a waiver to do so and we have to announce it in
4 *Federal Register* notice in advance of such
5 happening.

6 **DR. ZIEMER:** Yeah -- and comment?

7 **DR. MELIUS:** That last, Larry, a question on
8 that, and maybe the attorneys can help, maybe
9 they can't. Can you have -- given the nature of
10 the work of the Board, have a provisional
11 executive session announced that it would be
12 included in the schedule and that for each
13 meeting we could have a hour set aside for --
14 that would involve the review of confidential
15 information. We could specify what might be
16 entailed would be for this process.

17 **MR. ELLIOTT:** We're looking into that. It's
18 not only -- you know, it's FACA-related and also
19 legal-related, so we have to get some questions
20 answered, and we're working on that.

21 **DR. MELIUS:** I guess my ques-- I guess my
22 request is to look into that, that's all.

23 **MR. ELLIOTT:** And we are.

24 **MR. GRIFFON:** I guess that -- that was the
25 notion raised by that -- actually Roy brought up

1 that idea of having that standing -- having it be
2 a standing executive session, yeah.

3 **DR. MELIUS:** I didn't think I'd be original.

4 **DR. ZIEMER:** Proceed, Mark.

5 **MR. GRIFFON:** In section D, item D.3, again
6 this relates directly to the re-interviewing, and
7 I've highlighted it for potential deletion as it
8 applies to these dose reviews under this task
9 since we're not re-interviewing.

10 **DR. ZIEMER:** So item D.3 currently is being
11 deleted?

12 **MR. GRIFFON:** Yeah.

13 **DR. ZIEMER:** On item D, Mark, I wanted to
14 ask, where you say experts in item 1, and you
15 have, quote, experts.

16 **MR. GRIFFON:** Right. We don't define it, do
17 we?

18 **DR. ZIEMER:** Does that mean -- what does the
19 quote mean here? For example, are workers
20 considered experts in this context, 'cause that's
21 what you've listed, amongst other things. They
22 are experts in their own way --

23 **MR. GRIFFON:** Yes, yeah, that was --

24 **DR. ZIEMER:** -- was that the intent?

25 **MR. GRIFFON:** Right.

1 **DR. ZIEMER:** That this is experts, considered
2 in a very broad sense.

3 **MR. GRIFFON:** Right.

4 **DR. ZIEMER:** People with --

5 **MR. GRIFFON:** Shop floor, 30-year --

6 **DR. ZIEMER:** -- special knowledge --

7 **MR. GRIFFON:** -- experience and -- yes.

8 **DR. ZIEMER:** Okay, I just wanted to
9 understand the --

10 **MR. GRIFFON:** Right.

11 **DR. ZIEMER:** Right.

12 **MR. GRIFFON:** In item E, number 4, I added a
13 similar line, but we also have to look into this
14 again, that the Board may consider a standing
15 executive session for more in-depth discussion of
16 individual cases, so that's item E.4.

17 **DR. ZIEMER:** I want to go back, though.

18 **MR. GRIFFON:** Okay.

19 **DR. ZIEMER:** And this may require legal
20 advice at some point, but can we legally go back
21 to any experts, whether it's workers or worker
22 representatives, and discuss any particular case
23 with them? And I just raise that in terms of
24 privacy issues. I can understand talking to
25 people about say site profiles. But if we're

1 looking -- reviewing a case, John Doe, John Doe's
2 claim, in what way can we talk to a technical
3 expert -- or any expert -- on that claim?

4 **MR. ELLIOTT:** You can talk to them about the
5 generalities of the claim. You cannot speak to
6 them about the individual by name, Social
7 Security number. You could talk about
8 generalities like job title, years employed,
9 facilities worked in, those kinds of things. But
10 you can't reveal privacy information.

11 **MR. GRIFFON:** I think maybe we need to
12 clarify that, but that was the intent. It wasn't
13 about -- it wasn't intended to have meetings with
14 experts to discuss a particular case, but rather
15 background information related -- potentially
16 related to that case, without identifying the
17 individual.

18 **MR. ELLIOTT:** Right. When we go after
19 coworker interviews, we have to do so with a
20 waiver from the claimant.

21 **DR. ZIEMER:** Specific from the claimant.

22 **MR. ELLIOTT:** Right, and --

23 **DR. ZIEMER:** But here you wouldn't be able to
24 do that.

25 **MR. ELLIOTT:** We wouldn't invoke that at this

1 point.

2 **DR. ZIEMER:** So this would pretty well be
3 restricted to something that would look a little
4 more like site profile type of information --
5 what kind of work was being done by -- you could
6 probably say by mill workers in some areas.

7 **DR. MELIUS:** (Off microphone) Target a site
8 profile.

9 **DR. ZIEMER:** Yeah, right. So it's in that
10 context that -- if in fact you had to do this,
11 that it would be...

12 **MR. GRIFFON:** Just to continue -- is it all
13 right to continue on, Paul? Is --

14 **DR. ZIEMER:** Sure.

15 **MR. GRIFFON:** E.6, I think it says on a
16 periodic basis, and to make that consistent with
17 the task that we just approved, I put on a semi-
18 annual basis.

19 Then on F.3, I modified that to say the full
20 Board, along with the contractor, will develop
21 semi-annual reports for HHS.

22 And then similar in G.3, corrective actions
23 in their semi-annual reports, the last sentence
24 in G.3.

25 **DR. ZIEMER:** Okay, are there other comments?

1 **MR. ELLIOTT:** Could I make a suggestion on
2 the last one there where you're going to bring
3 recommendations to NIOSH? I would certainly hope
4 that if you find something in your audit that is
5 a deficiency that we could correct, you'd not
6 wait.

7 **DR. ZIEMER:** Right.

8 **MR. ELLIOTT:** You'd let us know. So maybe if
9 you could think about an edit to that sentence
10 that would allow you to report sooner than -- you
11 know, at whatever time information becomes
12 available or...

13 **DR. ZIEMER:** The intent particularly would be
14 for corrective action recommendations should be
15 made in a very timely fashion.

16 I want to ask again on this procedure, Mark,
17 it's probably not so critical that this
18 necessarily be approved today, but we at least
19 want some preliminary indication from the Board
20 that this is going in the right direction, that
21 it's covering what we want and so on.

22 I want to raise an idea for people to mull
23 over and cogitate with respect to the issue that
24 you've currently deleted here and that's the
25 issue of the interviews. It seems to me that --

1 well, I have had a personal objection to the idea
2 of going back and talking with people after cases
3 were closed, and tried to think about how we
4 might accomplish the evaluation of the interview
5 process that we talked about without having to go
6 back and interview people after the fact. And
7 recognizing at the same time that NIOSH would be
8 very concerned about taping all interviews and
9 that kind of thing, here's an idea to think
10 about.

11 What if NIOSH were to consider taping or
12 recording or transcribing a small fraction of the
13 interviews, perhaps two to three percent, on a
14 random or similar basis, so that, for their
15 purposes, there could be an internal quality
16 control and for our purposes there could be a
17 record for which -- against which the summary
18 interviews could be in fact compared. The idea
19 then would be that the burden of recording
20 everything would be decreased to a very small
21 level -- and again, NIOSH would have to consider
22 this and see whether it's feasible. We would
23 have a specific record of the interview against
24 which summaries could be compared.

25 Now it seems to me that this could meet our

1 needs as well as being actually somewhat useful
2 to NIOSH in showing that they have in place an
3 additional quality review process. In fact, I
4 guess I would argue -- and I think we heard
5 counter-arguments before. I would argue that
6 this would help NIOSH in cases where appeals
7 occurred.

8 In any event, that's the idea I wanted to
9 float and to get -- kind of get a reaction from
10 people, both staff, Board members, as to whether
11 or not that would be a -- a way of coming at this
12 thing without having to open the cases in the
13 sense of going back to workers and re-
14 interviewing them after the fact, which we said
15 was only for the purpose of validating or
16 evaluating the review -- or the interview
17 process, in any event.

18 So now that -- you all have stunned looks on
19 your faces, but I -- and maybe -- maybe you just
20 want to cogitate on that and think about it and
21 react next time. Henry?

22 **DR. ANDERSON:** I thought we'd talked about
23 that or made that as an option or a proposal
24 earlier and it was --

25 **DR. ZIEMER:** I don't recall.

1 **DR. ANDERSON:** Maybe it was in the work--
2 maybe we just talked about it, but I --

3 **MR. GRIFFON:** We talked about transcripts,
4 but not -- blanket, I guess, was really --

5 **DR. ZIEMER:** I'm talking --

6 **DR. ANDERSON:** Yeah, I mean I would --

7 **DR. ZIEMER:** I'm talking about a very small
8 sample of approximately two percent, which could
9 serve our purposes as --

10 **DR. ANDERSON:** I would think that would --

11 **DR. ZIEMER:** In fact --

12 **DR. ANDERSON:** -- that would work.

13 **DR. ZIEMER:** In fact, one could take that
14 sample and do a separate study -- audit the
15 interviews -- aside from the case audits.

16 **DR. ANDERSON:** Right, yeah, I mean that --

17 **DR. ZIEMER:** 'Cause not ever case that we
18 audited would have --

19 **DR. ANDERSON:** Right.

20 **DR. ZIEMER:** -- necessarily such an
21 interview, but one -- one could even do a
22 separate audit study.

23 **DR. ANDERSON:** Sure.

24 **DR. ZIEMER:** It's just an idea. Okay. Jim.
25 Oh, Henry, you still on? Okay. Jim.

1 **DR. MELIUS:** As you probably know, I feel
2 very adamant that we should be going back and re-
3 interviewing. I think it's a valuable source of
4 information. But I also think -- I know other
5 people feel just the opposite and I think that we
6 ought to be exploring alternatives like that as
7 part of our -- my concern is the -- we need a
8 process to make sure that the interviews are
9 collecting the appropriate necessary information
10 and that there needs to be a -- both an internal
11 process within NIOSH for continuing to improve
12 those interviews and gather more information, as
13 well as our ability to review that. My position
14 that we need to go back and re-interview would
15 certainly be modified or could be modified,
16 depending on what NIOSH's own process was for
17 monitoring, as well as improving, you know --
18 steps to improve the interview process. So I
19 think something like that certainly is worth
20 exploring, if it can be. As I said, following --
21 I mentioned it before, it was sort of rejected
22 out of hand, so we really haven't explored that
23 and certainly be willing to do that.

24 I'd also think that maybe something that -- I
25 don't know whether it's part of Mark's group or

1 whether we want to set up another working group
2 that might really focus in on this whole issue,
3 not just from the perspective of the -- of our
4 review of the process, but what could be done to
5 improve the interview process, and maybe have
6 that group report back to -- to the Board. There
7 may be altern-- if not -- strongly objects or
8 cannot do this recording, then maybe there are
9 other alternatives that ought to be looked into
10 and we ought to be -- I think if we had a work
11 group we might be able to, you know, explore
12 those, present those and have a more complete
13 discussion of this issue.

14 **DR. ZIEMER:** Okay. Wanda?

15 **MS. MUNN:** It occurs to me that such a record
16 might also be helpful to us early on in
17 determining whether there is some trend with
18 respect to the reaction of people who are being
19 interviewed relative to the completeness of the
20 questions that they're being asked. If, for
21 example, in the first half-dozen interviews you
22 have two or three people who say well, why didn't
23 you ask me about something, then that might, as
24 you said, serve as an additional quality
25 assurance flag for NIOSH and as an information

1 item for us, as well. If we don't have negative
2 reactions from potential claimants to having that
3 done, it seems to me that it would -- would serve
4 multiple purposes and probably save a great deal
5 of time. Re-interviewing sounds like a very
6 tedious and very touchy item to me.

7 **DR. ZIEMER:** Incidentally, this could only be
8 done I think with the interviewee's knowledge.
9 That is, they would have to be told that -- well,
10 as I would envision it, it would be one of those
11 things where both the interviewer and the
12 interviewee would be told that the interview may
13 be taped or recorded for quality purposes. But
14 it would be important that the interviewer not
15 know that it was that -- that specific interview
16 was being taped, and also that the interviewee
17 had the option of saying I do not wish my
18 interview to be taped. I think that would be
19 important.

20 **MS. MUNN:** Or conversely, if the interviewee
21 chose to record the conversation themselves, they
22 could -- they would be free to do so.

23 **DR. ZIEMER:** I think we heard yesterday that
24 that may already be happening. Okay. Yes,
25 Larry.

1 **MR. ELLIOTT:** If I could, I'd like to offer
2 another option for your consideration, keeping in
3 mind that it's an audit that you're performing,
4 an audit of the process, an audit of the quality
5 control and quality assurance measures that we
6 have in place. We welcome that. I want that. I
7 want to know where we're deficient and I want to
8 improve. If you hear resistance in my voice, as
9 you've heard before, I'm not happy about going
10 back to claimants after the fact and interviewing
11 them. I have never said it's off the table, but
12 I've almost said that. I'm almost saying that
13 right now.

14 The offer I would make to you is, as part of
15 your audit, you and your contractor could observe
16 the interview process, follow it through to the
17 end. There's down sides to that, as well.
18 There's perhaps advantages. So I just offer that
19 for your thinking.

20 I would also encourage staff and counsel to
21 speak their minds about this issue because there
22 has been considerable discussion, debate,
23 concern. And as the person who identified
24 interviews as something that I wanted in this
25 program, I am very much interested in seeing us

1 do the best that we can with interviews. There's
2 no requirement in the statute for interviews.
3 This came from me. And I'm not trying to toot my
4 own horn here, but as an industrial hygienist, I
5 believe that the experts on the shop floor should
6 be heard. I believe that a worker who worked
7 within a process, whether that's a reactor
8 operator or an electrician or a painter or
9 whatever, we should hear how they viewed their
10 work experience. And that's the interest that I
11 had in making sure that we had this interview
12 opportunity. People can make a lot out of it or
13 they can belittle it. We've had some gains and
14 some advantages and some benefits from the
15 interviews that we've conducted. In many cases,
16 we've not. But in those that we have, I think
17 it's beneficial that we do it and we do it right.

18 So I encourage you to think about this. I
19 encourage you to think of ways that we can do
20 this and perform your audit that will identify
21 ways that we can improve the process without
22 touching the claimants after the fact. I just
23 don't see any benefit or good to doing that.

24 So again I've spoken my mind. I wanted you
25 to hear that. I encourage staff to speak up.

1 Staff and counsel can identify issues that they
2 know of associated with not only going back to
3 claimants after the termination of the case is
4 made, but also with regard to taping everybody,
5 taping two percent, what have you -- whether it's
6 you observing. I'm sure there are issues they
7 can identify with that, as well as you can. So
8 thank you. I encourage you to consider the
9 options available here and keep pursuing this
10 because I want to hear where we can improve.

11 **DR. ZIEMER:** Mike Gibson.

12 **MR. GIBSON:** I appreciate Larry's position on
13 that, and if I understood Dr. Ziemer right, this
14 two or three percent would be all that our
15 contractor may be re-listening to after the fact.
16 And if I understood Larry right, it would be
17 maybe a Board member and one of our auditors or
18 something would sit in on the conversation. And
19 it seems to me that, based on the reaction we've
20 heard from a lot of the public, that that may
21 intimidate them even more. I mean I've felt
22 reactions like they're up here blaming the Board
23 for what's going on instead of -- not the system
24 we're trying to implement. And it looks like to
25 me it may intimidate them even more in being

1 forthcoming with information. It's just a -- my
2 thoughts.

3 **DR. ZIEMER:** Larry, you were talking about
4 having Board members there observing the phone
5 conversation. The presence of those Board
6 members would have to be made known to the
7 interviewee, as well, perhaps, I suppose.

8 **MR. ELLIOTT:** Well, you know, I --

9 **DR. ZIEMER:** Well, we don't know --

10 **MR. ELLIOTT:** I obviously haven't -- I
11 haven't thought through this myself, and we have
12 had Board members, as you know, some of you have
13 observed some of the interviews, overheard them,
14 sat with the interviewee and the interviewer. I
15 think it would take perhaps some legal review to
16 determine whether or not -- in order to prevent
17 bias of the interview process -- that you could
18 do this, you know, on line without the
19 interviewer or the interviewee knowing. I don't
20 know if that can be done or not as part of your
21 audit. Maybe it could be done with a simple
22 statement at the start of each interview that
23 this -- and we are -- we are -- in our process,
24 we are listening in to interviews for quality
25 purposes. So you know, we could look into that

1 if that's an option that you want to pursue and
2 you think you're interested in. But it'd take a
3 little more work and thought I think to put into
4 play -- as any one of these options would.

5 **DR. ZIEMER:** Robert?

6 **MR. PRESLEY:** I really don't think that it
7 would -- that the people would be intimidated by
8 it. I actually think that some of them out there
9 might be glad to have a Board member listen to
10 where that they would know that we were taking an
11 interest in something that they were doing or
12 saying. I don't -- I don't think it would
13 intimidate people at all.

14 **DR. ZIEMER:** Thank you. Henry?

15 **DR. ANDERSON:** I guess what -- one thing that
16 would be helpful is when -- right now NIOSH is
17 already sitting in on some of them for quality
18 control. Are notes taken? Do you parallel fill
19 out the form? I mean going through the interview
20 form that's now kind of on line and the database,
21 clearly there's a lot more discussion that went
22 on between the interviewer and the interviewee
23 that gets converted into a check box. And I
24 guess one of our issues in the audit would be
25 that kind of winnowing process, was that done

1 consistently and appropriately. One way to
2 evaluate it is if the individual writes back
3 saying gee, I told you about XYZ and you didn't
4 include it. That is easy -- you can easily see
5 that.

6 On the other hand, if somebody's listening in
7 and is parallel filling out the form or writ--
8 taking notes, then if those notes were available,
9 you'd be able to make those comparisons versus
10 passively listening, which would be more is the
11 person's demeanor appropriate, are they
12 belittling the person or are they being
13 supportive and are they good interviewers. That
14 clearly is -- you know, a NIOSH activity more
15 than us, are they doing it -- but if there were
16 notes, that I guess is -- and does the
17 interviewer take notes besides just on the CATI
18 system or how -- how is that done? I mean it's -
19 - I guess our concern or my concern is about
20 potentially information lost, that you're
21 listening to this interview and you're writing
22 down what you think is important and somebody
23 else might view -- that's information that, boy,
24 because you have special knowledge, is useful.

25 **MR. ELLIOTT:** Well, I think all of that would

1 -- would be examined in your audit and would be
2 evaluated appropriately. And certainly, you
3 know, what -- whatever quality assurance process
4 that we have, as well as -- we look at quality
5 control being different than quality assurance.
6 Quality control is as you're working through,
7 developing a product, you make efforts and take
8 steps to assure your quality is in control. At
9 the end of the process, you evaluate has your --
10 is the quality that you wanted to achieve there,
11 you assure your quality at the end. And all of
12 that certainly would be fodder for your review
13 and the audit.

14 Let's be clear on one thing, though. The
15 claimant controls this. The claimant has the
16 opportunity to come back and say hey, I told you
17 about this and you didn't capture it in my
18 report. And you can see how many times those
19 edits have been made to make corrections based
20 upon claimant interest. I think it's there. I
21 think you need to go through the process of the
22 audit, the practice of the audit, figure out what
23 areas we can improve upon and where we're
24 deficient and certainly be very much welcome of
25 that.

1 **DR. ZIEMER:** Tony?

2 **DR. ANDRADE:** Thank you. Larry, the first
3 order, I think you're absolutely correct. That
4 type of analysis is easily done and should be
5 done and should be part of the independent review
6 process here.

7 However, I really like your idea about
8 perhaps observing and/or sitting in on --
9 listening in on conversations in which the
10 interviewee has agreed and would really like to
11 have a Board member sitting there. I think both
12 Bob and Mike are correct. There's going to be
13 some people that are just not going to be
14 comfortable speaking to two people. And in other
15 cases, there are folks that would just love to
16 tell their story to the world.

17 So if we could have two independent set of
18 note-takers, as the idea was raised, and have
19 those notes compared at the end, I think that
20 goes into the second order -- level of
21 information that would perhaps give us some
22 indication as to whether one person is biased in
23 taking down certain types of information rather
24 than -- as opposed to the other.

25 **DR. ZIEMER:** Yeah. Tony, let me make sure

1 that I understand your comment with respect to
2 individuals welcoming a Board member being
3 present. It seems to me we do not want either
4 the interviewer or the interviewee to know
5 specifically that the conversation is being
6 audited. That has -- that can have the potential
7 of perturbing the system that you're trying to
8 check. An audit, to me, has to be blind to that.
9 We don't want interviewers behaving differently
10 because a Board member's on line than they would
11 otherwise -- being nicer, being more thorough or
12 whatever it may be. So -- and so I thought I
13 heard you say that there would -- might be two
14 people asking questions. I think it would
15 perturb the system to have Board members asking -
16 - or maybe I misunderstood.

17 **DR. ANDRADE:** I'm sorry, yes, let me clarify
18 that. First of all, the situation would be
19 presented to the interviewee as you might
20 possibly be -- or information might possibly be
21 taken by two people, and one being a Board
22 member. And then you go through the normal
23 interview process, but you have the second person
24 taking down their own set of responses. Okay?

25 **DR. MELIUS:** Two comments. One is back to

1 the idea of parallel interviews or listening in,
2 whatever. I think when we discussed this before
3 at a meeting, the concern came up about this
4 issue that we were only going to be auditing
5 completed cases, and these would not be --
6 obviously be completed, so it would involve a
7 change in that directive parameter in our audit
8 process, so we'd have to think through that.

9 And I don't want to cut off discussion of
10 this, but I do think we're going to need -- I
11 think setting up a work group to look into this,
12 look into what current practices are, look into
13 the alternatives and what would -- could be done
14 legally, what can be done programmatically and
15 what would satisfy everybody involved. I think
16 it would be helpful to get this moved along
17 'cause it's a contentious and it's a difficult
18 issue to resolve.

19 **MR. NAIMON:** I'm not here to give any instant
20 legal opinions, but -- no, there are no such
21 things as instant legal opinions. I just thought
22 I would mention to you some of the issues that
23 are involved in -- we looked -- at some point we
24 looked at taping in great detail. I think
25 listening in may have -- may all have some of the

1 same issues. Dr. Ziemer mentioned that the
2 validity would be significantly helped by the
3 fact that someone was listening in not being
4 known to the interviewer or the interviewee.
5 There would be a significant legal question in
6 some states as to whether that's possible. And I
7 think as a practical issue, when you're dealing
8 with these different laws in different states,
9 that you probably don't want to get into a
10 situation where you are picking at which places
11 you're listening in on and which places you're
12 taping, based on where the interviewee is
13 geographically located.

14 If we did have tapes for even a sample of the
15 interviews, they potentially would have to be
16 added to the administrative record for that
17 claim. You also would have the possibility the
18 claimants, when asked for their permission, would
19 ask for copies of those tapes and so there would
20 be an issue of providing those copies. There
21 will be, for some people, a chilling effect to
22 the idea that something is being recorded or
23 listened in. For other people, obviously, they
24 might like the idea that it's being recorded or
25 someone listening in. I think that varies a lot

1 based on the individual person.

2 The states that have the most significant
3 requirements when it comes to taping, there's one
4 state in particular that has a requirement that
5 every party on the phone call give its consent
6 and give it on tape, so essentially what you
7 would have is you'd have to have each person who
8 participates say that it's okay with them, and
9 then you'd have to go turn the tape on and say it
10 again in order to verify that each person has in
11 fact -- has in fact said it. And I think that
12 would also be a protection for us in this case
13 that -- you know, the consent would be very
14 thoroughly noted so there's no issue later as to
15 -- as to what that is.

16 So Dr. Melius was correct that this is a --
17 this is a very complicated question. I just
18 thought you'd want to hear what some of those
19 factors are.

20 **DR. ZIEMER:** Thank you very much. Other
21 comments? It wasn't my intent that we solve this
22 today, and in fact simply wanted to get some
23 ideas on the floor that at least get us thinking
24 about some options so that we -- otherwise we
25 were going to be very polarized. It was sort of

1 an all or nothing kind of thing and there are
2 some options here that could be explored by a
3 subgroup or something like that. Jim.

4 **DR. MELIUS:** Can I formally propose that we
5 do a subgroup?

6 **DR. ZIEMER:** You certainly can do that. The
7 Chair will recognize you for that purpose. The
8 Chair recognizes Jim has proposed a subgroup to
9 explore possible options for the purpose of
10 conducting the audit of the interview process.

11 Does that capture -- I think that --

12 **DR. MELIUS:** Yeah.

13 **DR. ZIEMER:** -- that it -- are there any
14 objections to having such a work group? I'm just
15 -- 'cause the Chair's empowered to appoint work
16 groups. Richard?

17 **MR. ESPINOSA:** I'm in second on the motion.

18 **DR. ZIEMER:** Okay. It doesn't actually I
19 don't think require a motion, but if I have --
20 the sense of the Board is that we should proceed
21 with a work group. And as I say, the Chair is
22 empowered to do that. I would be pleased to have
23 interested individuals volunteer to be part of
24 the work group. Rich is interested, Tony's
25 interested, Jim's interested, Wanda. There's

1 four right there.

2 **UNIDENTIFIED:** How many can we have?

3 **DR. ZIEMER:** Five would be an upper limit --
4 Mike is interested. Okay. Okay, that will
5 compose -- comprise the work group, and we can
6 ask the work group to report at the next meeting.
7 We need some staff support on that probably, as
8 well, and --

9 **MR. ELLIOTT:** Do you have a Chair for that?

10 **DR. ZIEMER:** I'm thinking about -- yes, we
11 definitely have a Chair, I just don't know who it
12 is at the moment. Does anyone want to volunteer
13 for that job or I am glad to appoint somebody?

14 **DR. MELIUS:** (Off microphone) I'd be glad to
15 volunteer for that (inaudible).

16 **DR. ZIEMER:** Okay, Jim has volunteered and
17 you have -- you have the names of the colleagues.
18 And I would ask the work group to keep the Chair
19 of the Board in the loop on your deliberations.
20 I also have an interest in this, but I'll let you
21 folks deliberate on your own, but I do want to be
22 kept in the loop on this.

23 Larry, is there a person on the staff that
24 can assist them? There may be -- or at least be
25 available to address legal/technical issues that

1 might arise?

2 **MR. ELLIOTT:** Yes, we'll certainly make a
3 staff person available. I'm not sure yet --
4 right now who that would be, but general
5 counsel's also at the ready to help this work
6 group, so David Naimon and Liz Homoki-Titus will
7 avail themselves of the work group.

8 **DR. ZIEMER:** Okay. Well, the formal charge
9 to the work group will be to explore potential
10 options that the Board can consider for the
11 purpose of auditing the interview process. And
12 I've expressed it that way because I think it
13 might be helpful if we had before us maybe more
14 than one possible option. You know, what are the
15 pros and cons of doing it this way versus doing
16 it this way and maybe a third way. But I think
17 it's important to be somewhat creative on this.
18 We need to keep in mind -- I think we need to be
19 sensitive to all the issues. We sort -- you know
20 what issues we all have with each other and the
21 issues the staff have, and I think if we're
22 creative enough, we can find a solution that
23 satisfies all of our needs. The Board has
24 certain requirement. NIOSH has some certain
25 desires. We want to -- we want to be able to do

1 this in a way that's helpful to both -- all
2 groups involved.

3 If we find a good process, I hope it's one
4 that will also be helpful to NIOSH that they can
5 use internally for whatever sort of improvement
6 and -- continuous improvement that they might
7 find useful as part of the process.

8 Now we -- let's see, we don't require any
9 formal action on that. The work group is
10 appointed and it has its charge and Henry and
11 then Richard.

12 **DR. ANDERSON:** I just had a question for
13 NIOSH. Since we heard that some of the claimants
14 are already recording, do they say anything on
15 the phone that they're going to record? Do they
16 ask or -- I mean do you know -- I'm just -- this
17 is just a point of information.

18 And then the other question is how many have
19 more than one person sitting with them to assist
20 them with their interview on the other end of --
21 is that identified in any way?

22 **MR. ELLIOTT:** I can't answer either question
23 for you here today.

24 **DR. ANDERSON:** Yeah.

25 **MR. ELLIOTT:** It was news to me yesterday

1 that the interview was taped. My first query to
2 folks -- to staff was go find out whether or not
3 it's recorded on the interview itself that it was
4 taped.

5 I can't honestly answer your second question,
6 either, sitting here today. I don't have those
7 details in front of me. We do know that a number
8 of people -- particularly on the survivor side --
9 have people sit with them, people who are hard of
10 hearing, people who can't sit for longer than an
11 hour or who don't understand some of the
12 questions, there've been a goodly number,
13 perhaps, of those people having others sit in on
14 the interview. And we do take their names. We
15 know who -- you know, we identify who else is in
16 the room participating in the interview.

17 **DR. ZIEMER:** Rich?

18 **MR. ESPINOSA:** Yeah, over this issue, I'd
19 like to make the recommendation that labor unions
20 and advocacy groups be able to -- that we solicit
21 their comments, as well, on this phone interview.

22 **DR. ZIEMER:** I'm not sure -- and from a
23 practical point of view, how are you suggesting
24 this be done? I certainly glad -- we would
25 certainly be glad to have input, but are you

1 suggesting a formal process of soliciting
2 comments or --

3 **MR. ESPINOSA:** I think it could be done by
4 the working group over this issue, but groups
5 like the Los Alamos Project on Worker Safety, I'm
6 sure that they would have a big input on how the
7 phone interviews are going so far and what they'd
8 like to see done, whether they wouldn't mind
9 being recorded, as well as a lot of the other
10 labor unions like PACE -- sheet metal workers,
11 iron workers.

12 **DR. ZIEMER:** Okay, I understand what you're
13 saying. I'm trying to think of how practically
14 this could be done. It would seem to me that if
15 -- if it's to be done, you'd have to -- you
16 couldn't exclude -- you can't just do Los Alamos,
17 so it's kind of an all or nothing. And I guess -
18 - I guess -- I'm concerned about the practicality
19 of this -- getting formal input from many groups.
20 Those that are -- work more closely with labor --
21 Jim, do you have a suggestion?

22 **DR. MELIUS:** Well, I guess I would just say
23 that maybe our working group, when we present
24 options to the Board, would -- one of the things
25 to be considered was did NIOSH or the Board go

1 out and solicit more general input on this issue,
2 so that could --

3 **DR. ZIEMER:** After you've -- after you've
4 developed some options?

5 **DR. MELIUS:** Options, and so when we come
6 back for discussion, maybe that's something we
7 could, you know, bring up in the appropriate
8 context -- may be something that NIOSH should be
9 doing or has done. You know, they may have
10 gotten comments and that may be --

11 **DR. ZIEMER:** How does that sound to you,
12 Rich?

13 **DR. MELIUS:** -- and so we -- we consider it.
14 I think that's fair.

15 **MR. ESPINOSA:** Yeah, that -- that hits right.
16 That's fine.

17 **DR. ZIEMER:** At some point where we knew what
18 the options were -- I don't think at this point
19 we want the idea to float out there that we're
20 proposing to record all interviews again, 'cause
21 that wasn't what -- that's not at least what we
22 talked about here, so perhaps waiting till we see
23 what the options are might be helpful. Good.
24 Thank you.

25 Wanda, you had a comment?

1 **MS. MUNN:** (Off microphone) No, if we're
2 going to do it in task, that's fine.

3 **DR. ZIEMER:** Okay. Mark, I'm kind of back to
4 your original document here. I think what we
5 just discussed doesn't necessarily change what
6 you have here at this point. Depending on the
7 outcome from this other work group, you may have
8 some minor modifications, but that -- that could
9 be handled readily. Okay.

10 **MR. GRIFFON:** Yeah, I think we've separated
11 it out.

12 **DR. MELIUS:** Before we got talking about
13 interviews, my suggestion was going to be that we
14 give our -- I don't know if we want to call it
15 approval, but our general agreement with this
16 document as a sort of a structure for -- for what
17 it's intended to do and so forth, to the extent -
18 - and sort of ask the working group to go on to
19 work with NIOSH and so forth, just sort of fill
20 in some of these issues. There are some privacy
21 issues, some FACA issues and so forth that need
22 to be dealt with and that -- that as long as
23 we're in general agreement with the -- what's in
24 here, that -- and that we have not identified any
25 other issues that we feel would -- that we ought

1 to -- maybe we ought to have enough permission to
2 go back and start working with NIOSH with the
3 understanding that this would be not necessarily
4 fully approved yet --

5 **DR. ZIEMER:** All right. How about a motion
6 for provisional approval of the draft document?

7 **DR. MELIUS:** Just what I was thinking.

8 **DR. ZIEMER:** I know this is a very unsanitary
9 way of speaking, and that's taking the words out
10 of other people's mouths, but we've done that,
11 have we? Okay. That's the motion.

12 Is there a second?

13 **DR. DEHART:** Second.

14 **DR. ZIEMER:** Okay, seconded. Thank you.
15 Discussion?

16 (No responses)

17 All in favor of accepting the draft as a
18 provisional -- provisionally accepting the draft
19 on the procedure for processing individual dose
20 reconstruction reviews, please say aye.

21 (Affirmative response)

22 Any opposed?

23 (No responses)

24 And any abstentions?

25 (No responses)

1 The motion carries. Thank you.

2 We have three sets of Board minutes to
3 approve. You were hoping I would forget that.
4 Right?

5 **MR. GRIFFON:** I was just going to ask one --
6 and this is sort of a process thing, too, but one
7 question for the working group. If I was
8 considering coming to Cincinnati September 1st,
9 2nd, 3rd, sometime in that time frame -- it's
10 only two weeks away, but I think we need to be --
11 the contract's going to be awarded soon, we
12 think, I think we have to work with that in mind.
13 And also whether any of those dates would work or
14 not work with NIOSH's staff.

15 **UNIDENTIFIED:** September 1st is Labor Day.

16 **MR. GRIFFON:** September 1st?

17 **UNIDENTIFIED:** Is Labor Day.

18 **MR. GRIFFON:** Is Labor Day, oh, I'm off by a
19 week. Oh.

20 **DR. ZIEMER:** Might I suggest that the work
21 group just work this out separately? Okay.

22 **ADMINISTRATIVE HOUSEKEEPING AND BOARD WORK SCHEDULE**

23 The Chair will now entertain a motion for
24 approval of the summary minutes of the 14th
25 meeting, which is the meeting of March 28th.

1 **MR. PRESLEY:** So moved.

2 **DR. ZIEMER:** Is there a second?

3 **UNIDENTIFIED:** Second.

4 **DR. ZIEMER:** Are there any additions or
5 corrections to the minutes?

6 (No responses)

7 If not, all who favor approval say aye.

8 (Affirmative responses)

9 Any opposed, no?

10 (No responses)

11 Any abstentions?

12 (No responses)

13 Motion carried. The minutes of the 15th
14 meeting on May 1st. This was a teleconference
15 meeting.

16 **MR. PRESLEY:** Move approval.

17 **DR. ZIEMER:** Move approval. Second?

18 **MS. MUNN:** Second.

19 **DR. ZIEMER:** Additions or corrections?

20 (No responses)

21 All in favor, aye?

22 (Affirmative responses)

23 Any opposed, no.

24 (No responses)

25 Abstentions?

1 (No responses)

2 Motion carries. The minutes of the 16th
3 meeting held May 19th and 20th.

4 **MS. MUNN:** Move they be accepted. I've
5 provided a couple of typos --

6 **DR. ZIEMER:** Yes, typos and so on, just pass
7 on to Cori. Motion to accept the summary minutes
8 for that meeting --

9 **UNIDENTIFIED:** Second.

10 **DR. ZIEMER:** -- has been seconded and -- any
11 additions or corrections?

12 (No responses)

13 All in favor of accepting those minutes, say
14 aye.

15 (Affirmative responses)

16 Any opposed?

17 (No responses)

18 And abstentions?

19 (No responses)

20 The motion carries. Thank you. We are 15
21 minutes early on the public comment period --
22 well, okay, next meeting, while Cori's getting me
23 the list.

24 (Pause)

25 **MS. HOMER:** Why don't you guys throw out some

1 dates and I'll tell you whether they're
2 available.

3 **MS. MUNN:** How about mid-October?

4 **MS. HOMER:** Mid-October?

5 **DR. ZIEMER:** Well, first of all, we -- we can
6 ask the question as to whether there is a need to
7 meet in September. The -- we're thinking that
8 the contract award may come around the first of
9 October, apparently. Is there a need for any
10 Board action prior to that, Mark?

11 **MR. GRIFFON:** I just can't see us being re--
12 I mean the work group -- I'm going -- probably
13 going to have some other dates other than Labor
14 Day now, but I mean we're going to try to meet
15 early September, so I would say early October or
16 mid-October for the next Board meeting in case we
17 need full Board approval on tasks or whatever.

18 **DR. ZIEMER:** Okay.

19 **MS. HOMER:** There isn't a single week in
20 October that there's not at least two people
21 unavailable.

22 **DR. ZIEMER:** Okay. Did everybody hear that?
23 There's no weeks in October where -- where at
24 least two people are out each -- each time. Is
25 that correct?

1 **MS. HOMER:** That's correct.

2 **DR. ZIEMER:** How does early November? Is
3 that getting too late? We may have to go --

4 **MS. HOMER:** Same thing.

5 **DR. ANDERSON:** What about 6th or 7th?

6 **MS. HOMER:** What dates?

7 **DR. MELIUS:** 6th or 7th.

8 **MS. HOMER:** 6th or 7th? Tony's not available
9 on the 7th.

10 **MS. MUNN:** I'm not available 6th or 7th.

11 **DR. ANDRADE:** What day is the 7th?

12 **MS. HOMER:** It's Friday.

13 **DR. ANDRADE:** I can make myself available.

14 **MS. HOMER:** Okay. And Wanda, you said you
15 weren't available --

16 **MS. MUNN:** No.

17 **MS. HOMER:** -- on the 6th?

18 **MS. MUNN:** Neither the 6th nor the 7th.

19 **MS. HOMER:** Okay.

20 **MR. GRIFFON:** Can we look back at October, or
21 are people sure they can't switch -- I mean I
22 know we don't have a week free, but maybe people
23 can --

24 **MS. HOMER:** The first week of October Jim and
25 Henry are unavailable the 1st and 2nd and Dr.

1 DeHart is unavailable the whole week. The second
2 week of October Tony is unavailable on Friday,
3 Jim's unavailable all week, Roy is unavailable
4 all week and there are two staff unavailable on
5 the 6th.

6 **DR. ZIEMER:** How about the third -- how about
7 the week of the 12th?

8 **MS. HOMER:** That week is pretty much wiped
9 out. It looks like you guys are going to have to
10 rearrange your schedules.

11 **MS. MUNN:** The 20th?

12 **DR. ZIEMER:** Yeah, there's several people
13 unavailable that week, aren't there? What about
14 the week of the 19th?

15 **MS. HOMER:** Henry's unavailable the 22nd
16 through the 24th, Tony's unavailable the 24th and
17 Jim is unavailable the whole week. The last
18 week, Henry is unavailable all week, Gen is
19 unavailable the 27th and 28th. It looks like the
20 -- maybe the 29th through the 31st we could get
21 by.

22 **DR. ANDERSON:** (Off microphone) I'm wiped out
23 the 30th and 31st, that's (inaudible).

24 **DR. MELIUS:** I'm okay the 27th and 28th.

25 **MS. HOMER:** Okay.

1 **DR. MELIUS:** Actually that whole week -- that
2 got canceled, so --

3 **MS. HOMER:** Oh, it did? Okay.

4 **DR. ZIEMER:** So 27th and 28th, who's not
5 available?

6 **MS. HOMER:** Jim --

7 **DR. MELIUS:** No, I am available.

8 **MS. HOMER:** He is available now. Henry's not
9 available the whole week.

10 **DR. ZIEMER:** Henry is not available the 27th
11 and 28th. Is --

12 **DR. MELIUS:** Actually I'm not available the
13 27th. I'll be available the 28th and 29th.

14 **DR. ZIEMER:** 28th and 29th, but some -- Roy,
15 you're gone the 29th?

16 **DR. DEHART:** No, I'm good the 29th.

17 **DR. ZIEMER:** The 28th and 29th -- Henry,
18 you're -- you're not available at all that week.

19 **DR. ANDERSON:** Yeah, I'm on vacation in Italy
20 and I'm not giving that up.

21 **DR. ZIEMER:** Well, that's --

22 **DR. ANDERSON:** I'll call in, though.

23 **DR. ZIEMER:** Okay --

24 **MR. ELLIOTT:** Do we know Leon's availability?
25 Did he contribute here?

1 **MS. HOMER:** I did not get a response from
2 him.

3 **MR. ELLIOTT:** Okay.

4 **DR. ZIEMER:** First week in November again?

5 **MS. HOMER:** First week in November?

6 **MR. ESPINOSA:** What was wrong with the last
7 week in September?

8 **DR. ZIEMER:** Of September?

9 **MS. HOMER:** Jim's unavailable the 30th and
10 Roy's unavailable the whole week.

11 **MR. GRIFFON:** (Off microphone) And I'm not
12 available.

13 **DR. ZIEMER:** Mark's not available.

14 **MS. HOMER:** Oh, okay.

15 **DR. ROESSLER:** What about the week of the
16 22nd of September?

17 **MS. HOMER:** Henry's unavailable and Jim is
18 unavailable.

19 **DR. ROESSLER:** Are you in Italy then, too?

20 **DR. ANDERSON:** No, I'm fishing in Alaska.

21 **DR. ZIEMER:** What week was that, September --

22 **MS. HOMER:** The last week of -- well, I have
23 the last week of September the 28th, 29th and
24 30th -- or the 29th and 30th.

25 **DR. ROESSLER:** But we were talking about the

1 22nd.

2 **MS. HOMER:** Yeah, the 22nd, Henry's
3 unavailable, Tony's unavailable on Friday, Jim's
4 unavailable the whole week and Roy's unavailable
5 the whole week.

6 **DR. ZIEMER:** First week in November?

7 **MS. HOMER:** First week in November.

8 **MR. ELLIOTT:** I appreciate the Board's
9 interest to have all members present, but keep it
10 in mind that to conduct the business of the Board
11 you don't -- you only have to have a quorum.

12 **MS. HOMER:** Yeah. Okay, first week of
13 November, Henry's unavailable Monday and Tuesday,
14 Jim's unavailable Monday and Tuesday, so that
15 leaves the 5th, 6th, and 7th.

16 **MS. MUNN:** I'm unavailable the 7th.

17 **MS. HOMER:** That's right, Wanda's unavailable
18 the 7th.

19 **MS. MUNN:** 6th and 7th.

20 **MS. HOMER:** 6th and 7th.

21 **DR. ZIEMER:** It looks to me like we only lose
22 one person then October 28th and 9th. Right?
23 Is that correct?

24 **MS. HOMER:** Uh-huh, that's correct.

25 **DR. MELIUS:** What if we just went the extra

1 week and -- we're just delaying a week to do the
2 5th and 6th.

3 **DR. ZIEMER:** I thought the 5th and 6th we had
4 more people missing.

5 **DR. MELIUS:** No, just --

6 **MS. MUNN:** We do have more missing. I'm not
7 here.

8 **DR. MELIUS:** Oh, I thought you just said the
9 7th.

10 **MS. MUNN:** No, I travel on the 5th.

11 **DR. MELIUS:** Oh, I'm sorry.

12 **MS. MUNN:** The 6th and 7th I --

13 **DR. MELIUS:** I'm sorry.

14 **MS. HOMER:** For the 6th and 7th, Wanda would
15 be unavailable.

16 **DR. ZIEMER:** Is that the only one?

17 **MS. HOMER:** That's it.

18 **DR. ZIEMER:** So on the 28th and 29th one
19 person unavailable, 5th and 6th one person
20 unavailable. Any preferences? We could go
21 either.

22 **DR. MELIUS:** Figure out the location and then
23 just some logistics. Where are we going to have
24 the meeting?

25 **MS. HOMER:** Yeah, we need to know.

1 **DR. ZIEMER:** We don't have to be in
2 Cincinnati for any reason at that point, do we?

3 **DR. MELIUS:** I'll propose St. Louis for the
4 location. We talked about that before and --
5 continued interest and...

6 **MR. ELLIOTT:** Looks to me like, from my
7 perspective, the 28th and 29th would be best. I
8 -- the 6th and 7th -- and the next week is not
9 good, so...

10 **DR. ZIEMER:** Let's try 28th and 29th of
11 October. Any objection to St. Louis? Very
12 central location. Bob?

13 **MR. PRESLEY:** Do we need to be going back to
14 Washington any time?

15 **DR. ZIEMER:** D.C.?

16 **MR. PRESLEY:** Yes, sir.

17 **DR. ZIEMER:** Do we --

18 **MR. PRESLEY:** That was discussed at our last
19 meeting. I mean...

20 **MS. HOMER:** It's up to the Board.

21 **DR. ZIEMER:** We don't need to, specifically.
22 St. Louis is a potential site where we might have
23 some worker interaction, so I think that
24 certainly meets our intent. Any -- Cori, if you
25 would check on St. Louis and see if -- what's

1 available on the 28th. Is that agreeable? Any -
2 -

3 **MR. ELLIOTT:** Give us an alternate.

4 **DR. ZIEMER:** Alternate date or alternate
5 city?

6 **MR. ELLIOTT:** Alternate city.

7 **DR. ZIEMER:** Alternate city?

8 **MS. HOMER:** San Francisco? Santa Fe?

9 **DR. ZIEMER:** What about other locations near
10 sites? We've been to Oak Ridge, we've been down
11 to South Carolina. We haven't been to Richland.

12 **DR. MELIUS:** Yeah, Hanford's one we should go
13 to.

14 **MR. ELLIOTT:** Idaho.

15 **DR. ZIEMER:** What, Hanford in October?

16 **MR. PRESLEY:** We've talked about Texas.

17 **MS. HOMER:** I would suggest that the later in
18 the season we get, the bigger the city we want to
19 get into.

20 **MS. MUNN:** Yeah, but October's nice.

21 **MS. HOMER:** Is it?

22 **DR. ZIEMER:** In Hanford? Uh-huh. Hanford,
23 back-up site? Okay.

24 **DR. MELIUS:** Henry'll be disappointed. He
25 loves flying into Hanford.

1 **DR. ANDERSON:** Boy, I gotta tell you, yeah.
2 That makes it a four-day meeting, one day out,
3 one day back.

4 **DR. ZIEMER:** Thank you.

5 **MS. MUNN:** My heart bleeds for you.

6 **DR. ZIEMER:** Thank you.

7 **MS. MUNN:** It's easy to get to Richland from
8 there. The hotel will come get you.

9 **DR. ZIEMER:** Okay, we've agreed to St. Louis
10 on the 28th and 29th of October, with a fall-back
11 position at Hanford if St. Louis cannot
12 accommodate us in the manner to which we are
13 accustomed. Is that right? Okay.

14 **DR. ANDERSON:** Do you want to pick another
15 date -- I mean the next meeting?

16 **DR. ZIEMER:** The next meeting beyond that?
17 Yeah, right. Well, we probably -- if we meet end
18 of October, we're probably talking about --

19 **MS. HOMER:** Possibly early December?

20 **DR. ZIEMER:** -- early to mid-December. Most
21 people don't like to schedule meetings beyond the
22 middle of December.

23 **MS. HOMER:** The week of the 7th of December
24 looks great.

25 **DR. ZIEMER:** Let's get it scheduled then.

1 All days are open?

2 **MS. HOMER:** All days are open.

3 **DR. ZIEMER:** The week of the 7th -- 9th and
4 10th? 9th and 10th of December. Meeting
5 location? Something a little more southern than
6 Hanford? Amarillo near the Pantex site?

7 **MS. HOMER:** Amarillo? Okay?

8 **MS. MUNN:** Let's do Amarillo.

9 **MS. HOMER:** An alternate?

10 **DR. MELIUS:** San Francisco.

11 **DR. ZIEMER:** Let's see, have we been near
12 Rocky Flats? Oh, yeah, we went to Denver, right.
13 Okay, we were in Denver. Are there other
14 locations that have... What did you write down?

15 **MS. HOMER:** Amarillo.

16 **DR. ZIEMER:** Okay. We had a lot of
17 alternatives kicking around for a fall-back
18 place, but...

19 **MS. HOMER:** Idaho Falls has jet service.

20 **MR. ESPINOSA:** Albuquerque.

21 **DR. ZIEMER:** Well, of course we were in Santa
22 Fe, so I'm not sure that --

23 **MS. HOMER:** That's pretty close. I don't
24 know if you want to mix things up a little bit or
25 not.

1 **DR. ZIEMER:** Anything in terms of Berkeley or
2 Lawrence Livermore? Berkeley and Livermore are
3 there.

4 **DR. MELIUS:** Sizeable -- that's come up
5 before.

6 **DR. ZIEMER:** How many claims do we have out
7 there, a lot? A small number.

8 **MR. ELLIOTT:** Over all the California sites,
9 not even 1,000.

10 **DR. MELIUS:** How many we have from Pantex?

11 **MR. ELLIOTT:** About 1,000.

12 **MS. HOMER:** Would you like me to use one of
13 the other identified cities as a fall-back?
14 Wherever we don't have the meeting?

15 **MS. MUNN:** What about Nevada?

16 **MR. ELLIOTT:** Let me offer something here.
17 The number of cases we have per site shouldn't
18 drive where we go. In fact, I would argue that
19 for a site like Pantex where we're worried about
20 the cases coming out of that site, or Hanford
21 where we can't seem to get people to sign up --
22 or DOL can't get people to sign up -- it makes
23 some sense to go. So it could go the other way.
24 I mean, you know -- you know.

25 **MS. MUNN:** Isn't Nevada a reasonable back-up

1 for Amarillo?

2 **MS. HOMER:** That time of year it'd be nice in
3 Vegas.

4 **MR. PRESLEY:** You've got 400 and something
5 claims at the test site.

6 **DR. ZIEMER:** Okay, test site.

7 **MS. HOMER:** Okay?

8 **DR. ZIEMER:** Thank you.

9 **PUBLIC COMMENT**

10 We're right on schedule for public comment
11 period. Our first commenter will be John
12 Alexander, Center for Worker Health and Safety
13 Education, I believe, in Cincinnati. And John?

14 **MR. ALEXANDER:** First off, I work at the
15 ICWUC Center for Worker Health and Safety
16 Education here in Cincinnati, and I'm the United
17 Steel Workers of America liaison there. I travel
18 all over the country teaching health and safety,
19 including many of the places that you had up on
20 the screen here yesterday and today.

21 And there was one item that I wanted to at
22 least give my opinion on. I don't know what
23 that's worth, but before I do that, I want to
24 thank you for all the work that you guys are
25 doing. I think it's wonderful that you are doing

1 what you're doing and I believe it's something
2 that's certainly necessary, and it sounds like
3 it's an astronomical feat, but it's certainly
4 needed.

5 I hope I get these names right because I'm
6 going to comment on some of the things that were
7 said and what I think about those things. Dr.
8 Toohey -- is that right, the fella that was
9 sitting right over there? When he gave his
10 presentation he talked about the committee and
11 who's involved in the investigations, and I
12 believe Dr. Melius brought up the point about
13 conflict of interest. And then I think it went
14 over to -- I've got to put my glasses back on
15 here -- Brother Gibson and he brought up the fact
16 about there should be some craftsmen involved in
17 some of this discussion. And then it bounced
18 back around and then later on today -- this
19 afternoon Dr. Melius brought up about union
20 representation and then Richard brought up about
21 union representation again.

22 Now when Dr. Till gave his presentation --
23 and actually last night after I watched yesterday
24 afternoon and listened to what was being said, I
25 had a lot of stuff I wanted to say today, but I

1 think Dr. Till hit on a lot of the points that I
2 wanted to make and believe me, it was very
3 refreshing to hear him speak and the way he
4 eloquently covered the points. And I just -- and
5 I'm sure that he had just as much effect on you
6 folks as he had on me, and he certainly made some
7 very good points. And I think he identified a
8 few deficiencies that I was picking up yesterday,
9 just being here a half a day.

10 And one of them is who the committee is, and
11 Dr. Toohey -- I forget who exactly asked the
12 question, but they asked why the committee didn't
13 consist of -- with another representative --
14 union representative or representative of the
15 employee or someone on the Committee, and his
16 answer was because of the cost.

17 Now, you know -- I mean what we're doing here
18 is we're trying to -- that was what he said, it
19 had to do with the cost. And you can check your
20 minutes on that. I was paying pretty strict
21 attention to this.

22 But anyway, this is an investigation for
23 people to be compensated who've been injured,
24 possibly been injured. I mean that's what all
25 this is about -- right? -- to determine whether

1 or not they have.

2 Now just for your information, I found that
3 -- and I was trying to look for the right
4 adjective so I wouldn't insult anybody, so I'll
5 just stay I found it very unsettling that they
6 didn't have the union representatives of the
7 people involved in these committees where they're
8 doing these investigations 'cause I am a union
9 representative. I was the chairman of health and
10 safety for 15 different plants at one particular
11 time before I became a full-time instructor. And
12 believe you me, if you aren't investigating some
13 of the situations that took place in our
14 facilities, I know I could add a lot of
15 information to what actually happened as opposed
16 to what some of the people there would tell you
17 what happened. So -- so I'm certain that that's
18 the case in many of the situations of these --
19 these incidents that you're checking into.

20 But just out of curiosity, at lunchtime today
21 I went to one of my colleagues who's retired from
22 the government 20 years and I asked him this
23 question. I said if -- if you found out that you
24 had been overexposed to something and you
25 possibly had a disease because of that, and a

1 committee was going to be formed to determine if
2 in fact that exposure is what caused your disease
3 and you were to be compensated for it or not, who
4 would you want on that committee. And his first
5 answer -- he thought a little bit. He said well,
6 I'd sure want my union representative there. And
7 I started chuckling a little bit at that because
8 he had no clue what I'm attending here or, you
9 know, or what you guys are doing here.

10 And then I said well, who else would you want
11 on that committee? And he said well, the one
12 person I wouldn't want on there is my company's
13 safety representative. He says and then I would
14 want an outside source doing the investigation.

15 Now when you compare that to what Mr. Dewey
16 said -- or Toohey, who is on the committee, that
17 really makes you kind of wonder. And I went to
18 another colleague and I asked the same question.
19 He said there's only one person I'd want to make
20 sure wasn't on there. And I said who is that?
21 And he said the company health and safety
22 representative.

23 Now the reason I'm bringing this up is
24 because something that Dr. Till said. He said
25 that what you're doing here, you should try to

1 have a program that can withstand the scrutiny of
2 certain people looking at it and when it's all
3 done to say whether or not it was done correctly,
4 or whether or not it can withstand scrutiny. Now
5 it would appear to me that you're missing a very
6 vital point here, and it was brought up by some
7 of the own people -- your own people on your
8 panel, and when I listened to when you went over
9 your work goals or statement of work or whatever,
10 nowhere in there does it say anything about
11 having the person's representative contacted or
12 discuss the incident, but it does say any
13 important information or whatever the exact
14 verbiage is on there, to reconstruct an exposure.

15 Now let me tell you, from my own personal
16 experience, that would include the union health
17 and safety representative, where in fact there
18 are unions. You did bring up the one point that
19 the one facility doesn't have -- but they do have
20 union personnel there, but not very many. But
21 even there I think I'd want to talk to the union
22 personnel.

23 Remember, cost -- if -- and I just -- cost
24 shouldn't be an issue here, very much. I mean
25 it's an issue in anything, but cost is probably

1 one of the key issues that got us here in the
2 first place. And my job is to go out and prevent
3 from happening what has happened here in the past
4 today. And we still have the same battle going
5 on and cost is one of the key things that gets us
6 in these kind of predicaments. Everybody's
7 trying to figure out how to do the job the least
8 expensive way and not protect the workers the way
9 they should be. And so I don't think that cost
10 should prevent this committee from having a union
11 representative on the committee who's part of the
12 committee to figure out what actually happened in
13 some of these incidents.

14 So if you're going to have a program that's
15 going to withstand scrutiny, the one flaw that
16 I've seen -- and I'm not sure that there's not
17 other ones, I don't know. But the one flaw that
18 I've seen that sticks out sorely from yesterday
19 and today's conversations here is that, that's
20 what's lacking. So that's my opinion. You can
21 do whatever you want, but I really do think you
22 need to reconsider the verbiage that you have
23 here to -- to ensure that you're actually finding
24 out what did happen. And if you're really going
25 to give the benefit of the doubt to the worker,

1 as Dr. Till said -- and he gave a perfect
2 example, the one -- the guy with the airplane,
3 the mechanic -- right? He said they were giving
4 the benefit of the doubt to the worker, but did
5 they really? I mean the first cut, they said he
6 wasn't exposed. And if it wasn't for his own
7 persistence, it doesn't sound like there would
8 have been a second reconstruction, would there?
9 And on the second reconstruction, they determined
10 he still wasn't exposed because they really
11 wasn't giving him the benefit of the doubt. And
12 it wasn't till the third reconstruction that they
13 actually did figure out what did happen.

14 So you know, if it's going to be difficult on
15 some of these -- and I'm sure it is, on some of
16 them -- I would think if you're going to do an
17 investigation, you would want all parties
18 involved. And all parties who were involved in
19 maybe some of those incidents. Or otherwise
20 you're losing a very valuable asset. And that's
21 all I wanted to say. Thank you.

22 **DR. ZIEMER:** Thank you very much, John, for
23 those comments. Ask if any of the Board members
24 have questions for John?

25 (No responses)

1 Okay, thank you. Eula Bingham is here today.
2 Dr. Bingham is from the University of Cincinnati
3 Medical Center. Dr. Bingham, pleased to have
4 you, as well.

5 **DR. BINGHAM:** Thank you. I have a couple of
6 points, some of them really are similar to what
7 Mr. Alexander said. The one is a point of
8 clarification, and I guess this slipped by
9 somebody, but I work with a group -- I'm a member
10 of a team and John Dement*'s a member of that
11 same team, and Knute Ringen* heads it up, and we
12 have examined over 2,000 workers at Savannah
13 River. They've been interviewed. They've had
14 medical exams. And they're all members of
15 unions, over a dozen unions at Savannah River.
16 They are in that category of building trades.
17 They're carpenters, they're operating engineers.
18 We have an office there that brings in the people
19 to interview them for the worker history. The
20 office is run by Charles and Glenda Jernigan.
21 Charles is an electrician by trade, still a
22 member of the union. And Glenda, I'm proud to
23 say, is an operating engineer. So I do think
24 that there are people there who know that
25 facility very well.

1 Documentation was one of the issues that Dr.
2 Till brought up, and I would encourage -- for the
3 site profiles and anything else that's done --
4 that you need documentation. It's really at the
5 heart of good science. And you're going to be
6 judged on that.

7 Interestingly enough, the example that I'm
8 going to give to you about documentation has to
9 do with Savannah River. I didn't plan it that
10 way, but that's what -- the first one that came
11 to mind. When we were doing our investigations
12 and coming up with a site history about three
13 years ago, we went to Savannah River and met with
14 some of the people there. I was not at that
15 particular meeting, but some of our -- the rest
16 of our group was there. And the issue of whether
17 or not -- how many LPTs, lymphocyte
18 transformation tests, we would do for beryllium
19 came up. They said well, you know, there's no
20 beryllium here, never was any beryllium here.

21 We had a meeting with individuals down there,
22 many of whom were -- had to do with health and
23 safety, actually occupational disease, as a
24 matter of fact. Some were DOE employees and some
25 were contractors. And they said oh, don't worry,

1 there's no beryllium here.

2 We said well, you know, we've got five people
3 who are double positives on LPT tests. So they
4 allowed as how it was probably from the
5 fluorescent light bulbs. Somebody allowed to
6 them that we -- they thought Harriet Hardy had
7 done away with that 30 years ago or longer.

8 I will say that John Dement and I went back
9 to Savannah River and did a site visit, and they
10 still claimed that there was no beryllium there.
11 We continue to have positive tests, positive
12 sensitizations, and the production workers have
13 them, also. So I hope that when NIOSH or the
14 contractor gets information from a site, they
15 will document the source, because some of your
16 sources will tell you whatever is convenient.
17 And not just at Savannah River, all over. So to
18 CYA, you better document your sources or somebody
19 is going to find egg on your face in those site
20 profiles. Thank you.

21 **DR. ZIEMER:** Thank you very much, Dr.
22 Bingham. Any questions?

23 (No responses)

24 Okay. Our next person --

25 **MS. HOMER:** It's Richard Miller.

1 **DR. ZIEMER:** Oh, I couldn't read the -- it's
2 Richard Miller. Richard. No, I couldn't -- I
3 wasn't wanting to recognize him.

4 **MR. MILLER:** It's how I sign my checks. Take
5 note and put it on the web.

6 Good afternoon. I would just very briefly
7 like to underscore the question and discussion
8 that came up regarding conflict of interest. You
9 know, I sensed almost like the temperature went
10 up in the room slightly when the discussion was
11 raised about the -- just the mere disclosure or
12 providing transparency on the potential
13 professional conflicts of interest that might
14 arise from those performing site profiles. One
15 response was well, it's not in our contract.
16 Another response was we didn't require it in our
17 contract. And you know, this is a program which
18 prides itself on transparency and openness and
19 making sure things are documented and having an
20 open process for folks to come in the room. And
21 this was the first time I had ever heard
22 resistance to transparency. And I puzzled over
23 it and I'm not sure I fully understand it, but
24 let me offer some observations.

25 The first is is that it appears from just

1 these limited -- the technical basis team report
2 -- the report that Dr. Neton made which listed
3 those doing the 11 I guess site profiles, if you
4 go down the list you can kind of see why some of
5 these firms might readily be disqualified an
6 individuals from doing dose reconstructions under
7 the conflict of interest criteria that's in the
8 ORAU contract. In fact, they probably would be
9 disqualified because they are experts in
10 litigation defense and they would fall out on
11 that basis, at least with respect to certain
12 sites.

13 I had the pleasure of being on the other side
14 of one of these experts at a site -- Oak Ridge K-
15 25, Auxier & Associates -- and Auxier here is
16 listed as doing the K-25 technical basis
17 document. Now although it's a Special Cohort
18 site, obviously there's going to be a number of
19 claims that arise that are not SEC cancers. And
20 I puzzled to myself and I looked at the Fernald
21 site -- and of course Auxier was also the defense
22 expert in the Fernald litigation, which was --
23 you know, led to the Fernald settlement. And I
24 remember when Auxier was brought in in the Joe
25 Harding* case. I mean they've got a lot of

1 experience and they've -- they've been heavily
2 relied upon. I don't know about you, Dr. Ziemer,
3 but I imagine when you were there they were
4 heavily used by the general counsel's office for
5 a number of claims against the Department. And
6 so I can see why people are a little bit on edge.
7 Mel Chew, a very reputable guy, but you know --
8 great expert witness used in defense cases and
9 that -- and for his firm and was used -- is to
10 this day being retained, as I recall, in the
11 Marshall Islands defending the Fund. And I don't
12 know what all of the other activities are because
13 we don't have disclosure on it, but it would
14 seem, if the sensitivity is that there's
15 something that probably doesn't reflect well, the
16 answer to that is not to kind of do what DOE did
17 all these years was to put it in a drawer and
18 claim national security or it's in a -- you know,
19 critical proprietary information related to a
20 procurement or, you know, they have an array of
21 an excuses. And I don't know that that's the
22 right way to go about this.

23 Now there's really two issues that seem to --
24 that tier from this. The first is transparency
25 and the second issue is what do you do if you

1 find something really objectionable. And there's
2 probably a third one which I mentioned to Dr.
3 Neton earlier, which is as a manager managing
4 these site profiles, you should be able to at
5 least know that if you have contractors working
6 for you, you should know what filters they're
7 operating with, what -- either explicit or
8 unintentional, but you know, their basic
9 professional training. If you burrowed into the
10 Fernald case and spent all those years doing it,
11 well, maybe you view Fernald a certain way and
12 you don't have as open a mind as you might want
13 to have. It's not a -- it's not an explicit
14 thing. It may be just a -- you know, an
15 unconscious thing.

16 But it seems to me, as a program manager, you
17 all at NIOSH want to know what the professional
18 backgrounds of these individuals are because if,
19 to the degree and extent that these are cookie
20 cutters, or this is the dough out of which you
21 cut the cookie is what I should say, is if you
22 roll out the dough as your site profile and you
23 then lay in, you know, the cookie cutter -- and
24 I'm not sure it's going to be so simple at
25 Savannah River as it was at Bethlehem Steel --

1 but you know -- and Bethlehem Steel was -- there
2 -- that was the dough out of which each decision
3 was made. There wasn't much new information
4 needed other than the years of employment and the
5 age at exposure and the date of diagnosis.

6 And so it's worrisome, I think, not to have
7 that transparency and it's worrisome that the
8 program managers aren't at least having that as a
9 filter as they look at those working under them.
10 And I think it's worrisome that Dr. Toohey
11 doesn't have that in his focal point. And so I
12 hope that this fine point about procurement
13 doesn't interfere with clear, open transparency
14 on the professionals doing the work on these
15 projects. That's -- that's my suggestion.

16 **DR. ZIEMER:** Thank you, Richard. Again let
17 me ask if there's any questions on the part of
18 the Board members here.

19 (No responses)

20 I have a kind of a question myself. Maybe
21 I'll address it to you, but maybe to the Board,
22 as well, because it came up before, and that was
23 the fact that the site profile teams seem to
24 consist exclusively of technical people. It's
25 hard -- it's probably hard to find any sort of

1 unbiased person, whether it's a scientist or a
2 union person or whatever, on the site. But to
3 the extent to which one might include both,
4 wouldn't that be of benefit, for example, if the
5 union health and safety person from a site were
6 included? I don't know if maybe our first --
7 maybe Mr. Alexander suggested that. Mike sort of
8 hinted at it earlier in the day.

9 **MR. GIBSON:** That's exactly what I was
10 talking about.

11 **DR. ZIEMER:** And I think I heard Jim Neton
12 say maybe you would want to look at that as a
13 possibility. I don't -- it seems to me that that
14 would make a certain amount of sense, not only to
15 get some additional balance there, but maybe that
16 would help. I know it's very difficult in the
17 health physics community to find people that
18 don't at least have sort of appearance of
19 conflicts, even though they might not exist at
20 the time, that have baggage and so on, either --
21 I mean I do myself, so -- except for mine,
22 everyone else's baggage is pretty bad, but -- I
23 don't know, I'm -- it just occurs to me, and
24 others can react. It seems to me it would make
25 sense for the NIOSH staff to perhaps consider how

1 to address that issue.

2 And I guess I had always assumed that the
3 site profiles, the editors or the authors of
4 those would at least be identified. Are they not
5 being identified? I know they are on this list,
6 but in the reports themselves? No, I -- is there
7 a reason they're not?

8 **MR. ELLIOTT:** The benefit of having these
9 meetings are that we get this kind of input --
10 and very good points, you know. And we walk away
11 from these meetings and we have a laundry list of
12 good comments that we have to take into
13 consideration, and we certainly will address
14 these comments. You know, the -- let me answer
15 your question. No, right now this is -- perhaps
16 as an oversight on our part -- we haven't been
17 including the authors as listed in the technical
18 basis documents. We're going to look at that.
19 We're going to look at some of these other
20 issues, like how we engage --

21 **DR. ZIEMER:** And perhaps not only
22 transparency, but I think as Board members, we
23 would like to know that, as well.

24 **MR. ELLIOTT:** Sure, sure, and you know, this
25 issue of a balanced perspective, we want to

1 address that. We want to look at -- at how we
2 deliver the documents and, you know, make sure
3 everybody understands that this is a dynamic
4 document. The term "controlled document" I think
5 we take away from that our experience base in
6 government and know what that means, but on the
7 outside, we're now I think hearing a perspective
8 that that means something different to people on
9 the outside and it looks like it's a closed
10 system. Once you've got a controlled document,
11 it's done. Well, no. We want to make sure we
12 deliver the document in the appropriate context,
13 that it is a dynamic document where -- maybe we
14 got into a rush here to get the numbers done that
15 we all want to see done. But I'm not going to
16 make apologies for that. We're -- you know,
17 that's why we have these meetings. These
18 meetings are good for us in that regard. You
19 know, we do live in a glass house, and sometimes
20 we have to go to the toilet and I'm sure you
21 don't want to see us do that, but you know, we're
22 trying our level best and we do take this to
23 heart and we welcome the input, so --

24 **DR. ZIEMER:** Appreciate those comments.
25 Rich, do you have additional --

1 **MR. ESPINOSA:** Yeah. On the site profiles,
2 one of the things that I was kind of foreseeing
3 is having a union representative or worker
4 representative set up a worker forum for the
5 people that are doing the site profiles, such as
6 ORAU. That way they can -- you know, it could be
7 site by site, facility by facility, but they
8 could explain the -- the former workers could
9 explain the history and the current workers can
10 explain a lot of the history to current
11 situations now.

12 **DR. ZIEMER:** Mark?

13 **MR. GRIFFON:** Just to -- to offer -- from our
14 experience with the medical surveillance programs
15 that I work on, I can say that I've done risk
16 mapping sessions where we do group interviews.
17 And I've had group interviews with all former
18 workers, which are great. But I have to honestly
19 admit, the best sessions I've ever had are the
20 sessions where I get former shop floor workers
21 along with some management or supervisory people
22 and maybe a former health physicist --

23 **DR. ZIEMER:** Together.

24 **MR. GRIFFON:** -- and the dialogue usually --
25 I mean it's very helpful because the workers know

1 where things were, what they worked with. Often
2 they know code names, and then the technical
3 people can help me put radioisotopes with those
4 code names. And they also -- the supervisory
5 types -- at least when I first interview, when
6 the interview starts, they usually start off
7 presenting a picture of how it was on paper. And
8 then the workers will say come on, Joe, we're all
9 retired now, you know. You know it didn't work
10 that way. And then they'll kind of say well, it
11 was supposed to, but I got to admit, you know,
12 there were many occasions when we had to go
13 around this rule and that rule and here's sort of
14 how it was really. So they kind of check and
15 balance each other that way and it's very --
16 usually the best results is when we have that
17 kind of dynamic, so -- so I think that kind of
18 mix would be beneficial.

19 **DR. ZIEMER:** Yeah, and it occurs to me that
20 there may be some counterparts around these sites
21 to the old retired health physicists -- many on
22 that list are in that category, I think. There
23 may be some old retired union health and safety
24 folks around those sites that have some
25 institutional memory that would be of value, as

1 well.

2 Okay. Robert.

3 **MR. PRESLEY:** Yeah, I was going to say don't
4 -- don't leave out the retirees. They call us --
5 they call us graybeards, but at Y-12 we have what
6 we call the retiree corps, and they -- they take
7 in not only our Ph.D.'s, but all the way down to
8 our hourly people that worked on the floor. One
9 of the good points is -- is going back and
10 talking to these hourly people. Your shop
11 foremen, things like that, these people came up
12 through the ranks. They started out as hourly
13 people. Our plant manager for many, many years
14 at Y-12 started out as a chemical operator and
15 went all the way up to vice president of the
16 corporation, so don't forget the retiree corps.
17 They're there. I guarantee you that most of the
18 places have got them.

19 **DR. ZIEMER:** Roy DeHart.

20 **DR. DEHART:** I think the issue is not so much
21 whether it's union or not or management or not,
22 but the contribution they can make to the issue.

23 **DR. ZIEMER:** Right. Yeah, right on target.
24 Well, I think, as Larry's indicated, they've
25 heard these expressions of both concern and

1 interest and can take appropriate action.

2 Are there other matters that need to come
3 before us today?

4 (No responses)

5 Thank you very much. I think it was a
6 productive two days. We look forward to seeing
7 you all at the next meeting.

8 Oh, before you go, training session for --
9 which people? -- Wanda, Gen, Roy and me. Is that
10 it? Okay -- Mike, okay. Five of us tomorrow
11 morning. Okay. Four tomorrow.

12 Okay, we're adjourned.

13 (Meeting adjourned 4:30 p.m.)

14
15
16
17
18

C E R T I F I C A T E

STATE OF GEORGIA)
)
COUNTY OF FULTON)

I, STEVEN RAY GREEN, being a Certified Merit
Court Reporter in and for the State of Georgia, do
hereby certify that the foregoing transcript was
reduced to typewriting by me personally or under my
direct supervision, and is a true, complete, and

correct transcript of the aforesaid proceedings reported by me.

I further certify that I am not related to, employed by, counsel to, or attorney for any parties, attorneys, or counsel involved herein; nor am I financially interested in this matter.

WITNESS MY HAND AND OFFICIAL SEAL this _____ day of September, 2003.

STEVEN RAY GREEN, CVR-CM
GA CCR No. A-2102