

**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

**ADVISORY BOARD ON  
RADIATION AND WORKER HEALTH**

VOLUME I

The verbatim transcript of the Meeting of the  
Advisory Board on Radiation and Worker Health held  
at the Hyatt Regency Denver, Denver, Colorado, on  
Monday, July 1, 2002.

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July 1, 2002

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P R O C E E D I N G S

8:30 a.m.

1  
2  
3 **DR. ZIEMER:** Good morning, everyone. I'd  
4 like to call the meeting to order.

5 This is the fifth meeting of the Advisory  
6 Board on Radiation and Worker Health. Three of  
7 our meetings were face-to-face in Washington,  
8 D.C. One was a conference call, and now we have  
9 our fifth meeting here in Denver. We're pleased  
10 to be here and to have some of the local folks  
11 here with us today, as well.

12 I'm Paul Ziemer, Chairman of the Board. All  
13 of the Board -- the record will show that all of  
14 the Board members are present. And if some of  
15 you who are visitors have not had a chance to  
16 meet the Board, we're not going to have  
17 introductions this morning of the Board, but you  
18 can introduce yourself during the break or at  
19 some other time.

20 I would like to particularly indicate to  
21 members of the public, if you have not already  
22 registered your attendance with us there is a  
23 book in the back. Please do that. Also, if you  
24 wish to make a comment, a public comment later on  
25 in the meeting, please sign up so that we can

1 schedule that. There's a book back on the table  
2 for you to sign up for public comments.

3 Also on the table there are copies of today's  
4 agenda, as well as other informational items,  
5 some items from past meetings, the minutes of our  
6 past meetings, the recommendations of this Board  
7 from previous meetings, and other related hand-  
8 out materials including some of the materials  
9 that will be used today.

10 Since the last meeting there has been a  
11 working group that has been considering  
12 approaches that the Board could use in carrying  
13 out its responsibilities relative to the dose  
14 reconstruction activities, and we're going to  
15 hear from that subcommittee yet this morning, and  
16 have at least an initial look at what they are  
17 thinking and what they are going to recommend to  
18 this Board.

19 We have a number of other presenters today  
20 and tomorrow, as you see on your agenda. And by  
21 the way, the agendas are available on the table,  
22 too, if you did not get one. So we have a busy  
23 schedule before us for the next two days.

24 One of the important items is a proposed  
25 rule-making on special cohorts that we will be

1           considering today and tomorrow, if necessary.  
2           Particularly be thinking in terms of possible  
3           comments that the Board may wish to make on that  
4           rule-making.

5           I've indicated that we do have a full  
6           complement of the Board members here. As a  
7           matter of information I might tell you that it's  
8           my understanding that the White House Office of  
9           Personnel is considering making additional -- at  
10          least one, maybe two, additional appointments to  
11          the Board. I'm not quite sure where they are in  
12          that process, but it's my understanding that that  
13          is in process, and we may by next meeting have  
14          one or two additional members in place.

15          So we have a full schedule before us. We'll  
16          adjust the agenda if needed, based on how things  
17          go and how much time is actually needed for the  
18          different items on the agenda. In general we'll  
19          try to follow that agenda as closely as we're  
20          able to, but recognize that there is some  
21          flexibility, if necessary, to adjust the times of  
22          various activities.

23          We're going to move directly to the minutes  
24          of our last meeting, and I'm going to move myself  
25          back to my seat for that purpose, so if you'll

1 bear with me just a moment.

2 The draft minutes of the meeting of May 2nd  
3 and 3rd, 2002, are in your packet. I believe  
4 they were also on-line in advance so that even  
5 though the Board members didn't get their packets  
6 till last night, and I know many of you stayed up  
7 till long into the morning hours reading the  
8 materials, but you did have an opportunity to  
9 look at these earlier, about a week ago or so,  
10 on-line. I had the opportunity of going through  
11 these in detail myself prior to this version, and  
12 there were a few editorial changes. But now is  
13 the time to ask for any additions or corrections  
14 to the minutes.

15 Wanda.

16 **MS. MUNN:** I had no significant additions or  
17 changes, and I know it's word engineering, but on  
18 the very first page of the minutes --

19 **DR. ZIEMER:** Which page is it?

20 **MS. MUNN:** The very first page.

21 **DR. ZIEMER:** Very first page?

22 **MS. MUNN:** Uh-huh, next to the last sentence.

23 **DR. ZIEMER:** This is the executive summary or  
24 the minutes themselves?

25 **MS. MUNN:** This is the --

1           **DR. ZIEMER:** 1-5 or 1/5?

2           **MS. MUNN:** This is 1/5.

3           **DR. ZIEMER:** Okay.

4           **MS. MUNN:** The next to the last sentence,  
5 every time I read that sentence I get to the word  
6 "hazard" and it stops me. There are -- it seems  
7 to me that "jeopardize" is a better word,  
8 possibly "compromise," but in my mind  
9 "jeopardize" is much more straightforward and  
10 easily understood on first reading.

11           **DR. ZIEMER:** Any objection to substituting  
12 the word "jeopardize"? Probably grammatically  
13 that might be better anyway, even though someone  
14 might have said it this way.

15           (No responses)

16           **DR. ZIEMER:** Other corrections or additions?  
17 Yes, Dr. Roessler.

18           **DR. ROESSLER:** I'd just like to comment that  
19 somebody put in a lot of work on these minutes.  
20 They're very easy to read. They're very concise.  
21 They're just really good, good minutes. I think  
22 it's due to our people here, and perhaps, Paul,  
23 your going over them.

24           **DR. ZIEMER:** I would say it's mostly the  
25 staff effort. We thank them for that.

1           **MS. MUNN:** They need a gold star.

2           **DR. ZIEMER:** So you're not suggesting any  
3 changes to anything, thank you.

4           Again, corrections, additions, modifications?

5           (No responses)

6           **DR. ZIEMER:** Motion to approve with the minor  
7 correction given?

8           **MR. PRESLEY:** So moved.

9           **DR. ZIEMER:** Second?

10          **DR. DEHART:** Second.

11          **DR. ZIEMER:** All those who approve the  
12 minutes, say aye.

13          (Affirmative responses)

14          **DR. ZIEMER:** Any opposed?

15          (No responses)

16          **DR. ZIEMER:** Motion carries. The minutes  
17 stand approved.

18                 We are already ahead of schedule. You were  
19 supposed to take longer on these minutes than you  
20 did.

21                 If the staff is ready, we can move on to the  
22 NIOSH program status report. And Larry, would  
23 you introduce the staff members who participate  
24 here?

25          **MR. ELLIOTT:** Thank you.

1           We will start off this morning with your  
2 NIOSH program progress report or program report,  
3 which we've done in the past. I'll ask my  
4 Deputy, David Sundin, to present that to you  
5 today. I've had a number of things occupy my  
6 mind and my time since we last met, and he was  
7 gracious enough to take this role on.

8           And then he'll be followed by Bob Mansanares  
9 from the Department of Labor's District Office  
10 here in Denver to give you a report on DOL's  
11 piece of the program and the status in that  
12 regard. This was an action item that I took from  
13 our last minute -- or last meeting, that somebody  
14 expressed an interest to have that kind of a  
15 presentation as well.

16           So, Dave Sundin.

17           **MR. SUNDIN:** Good morning. I'm pleased to be  
18 with you here in Denver for your fifth meeting,  
19 and I've planned to give you a brief overview of  
20 program status. I'll be following the model that  
21 has been used in previous Board meetings.

22           June 30th marked the end of our third quarter  
23 of our fiscal year, so for many of these  
24 indicators I'll be able to give you statistics  
25 which show trends over three quarters, three full

1           quarters, and these are the three quarters that  
2           we've basically been receiving claims for dose  
3           reconstruction.

4           It's our understanding that the Department of  
5           Labor has received approximately 15,000 non-SEC  
6           cancer claims for which they're verifying  
7           employment and diagnosis, and they have  
8           transferred as of last week over 5,000 claims to  
9           NIOSH for dose reconstruction. You may recall  
10          that we began receiving claims from the  
11          Department of Labor on October 11th, 2001, and as  
12          you can see the number of claims referred to  
13          NIOSH has increased each quarter of this fiscal  
14          year.

15          You may also recall that each of DOL's four  
16          district offices sends us one batch of claims  
17          each week. We then send a letter to each  
18          claimant to let them know we've received their  
19          claim for dose reconstruction, and in that letter  
20          we also inform them of the steps their claim will  
21          go through and how they can contact us to monitor  
22          progress. We log each case into our computerized  
23          claims tracking system. We electronically scan  
24          all documents in each case file and also create  
25          and maintain a paper file system, which is

1 growing by leaps and bounds, as you might  
2 imagine.

3 We then identify, using the DOL referral  
4 summary sheet which accompanies each case file,  
5 the covered sites where the energy employee  
6 worked and the various jobs he or she held. We  
7 identify any NIOSH-held information that's  
8 pertinent to the claim, and this all permits us  
9 to focus our requests for radiation exposure  
10 information on specific locations and time  
11 periods, and to direct our requests to the  
12 appropriate DOE points of contact.

13 We're working very closely with DOE and the  
14 designated points of contact at the sites to  
15 ensure that we get the kind of exposure  
16 information needed to conduct the dose  
17 reconstructions in a timely manner. We continue  
18 to explore ways to expedite the fulfillment of  
19 our information requests, build site-specific  
20 profiles, establish efficient ways to access and  
21 evaluate sensitive information, and verify that  
22 no further information exists.

23 We're continuing our discussions with DOE on  
24 the terms of the Memorandum of Understanding  
25 between HHS and DOE on all of these points. The

1 purpose of this MOU, of course, is to set forth  
2 the guidelines for collaboration between HHS and  
3 DOE in carrying out our respective  
4 responsibilities under EEOICPA and the Executive  
5 Order. And I believe we're very close to having  
6 a document which both Departments can sign on to.

7         Within the last quarter we've seen an  
8 improved response to our requests for information  
9 from most of the DOE sites, and we expect  
10 continued improvement as each site becomes more  
11 familiar with our information needs and develops  
12 the capacity to respond.

13         We evaluate the information provided by DOE  
14 for accuracy and completeness in light of what we  
15 need for dose reconstruction. And where we  
16 determine that the information is incomplete or  
17 inadequate we follow up with DOE with additional  
18 information requests, and to date there have been  
19 51 such follow-up requests for additional  
20 information.

21         In some cases we've asked DOE to continue  
22 searching for information where none was provided  
23 in response to our initial request. Atomic  
24 weapons employer facilities are an example of  
25 this situation, and we have worked with DOE to

1 identify repositories of data which we can  
2 capture for our use in reconstructing doses for  
3 AWE claims in particular.

4 In other cases we're seeking site-specific  
5 information on historical dosimetry and bioassay  
6 practices and methods. And of course, this  
7 general information is valuable in that it could  
8 be used for the benefit of all claims relevant to  
9 that site and time period.

10 Once we've assembled and reviewed all  
11 relevant information from NIOSH records and  
12 received and examined the information from DOE,  
13 we schedule the interview with the claimant. As  
14 of today we've conducted 105 claimant interviews  
15 with employees and survivors. We currently  
16 actually have 127 dose reconstructions underway.  
17 This means that we've received, assembled,  
18 evaluated, and reviewed readily available  
19 information pertinent to the claim, and for 13  
20 claims we have completed the draft dose  
21 reconstruction report which is called for under  
22 our Rule 42 CFR 82. We've actually mailed out  
23 four draft dose reconstruction reports to  
24 claimants, including one claimant from Rocky  
25 Flats here.

1           This is followed up by a phone call from the  
2 dose reconstructionist who did the dose  
3 reconstruction. The purpose is to explain the  
4 report process and the findings of the dose  
5 reconstruction. We also seek the claimant's  
6 approval on an OCAS-1 form so that we can close  
7 the dose reconstruction process and move the  
8 claim on to the Department of Labor for  
9 determination of probability of causation.

10           At this point a comprehensive administrative  
11 record is also created for transmittal to DOL.  
12 This includes all documents in the case file, all  
13 information used in the dose reconstruction, all  
14 correspondence and phone calls with the claimant,  
15 and the input file for the NIOSH-IREP. One  
16 completed dose reconstruction and administrative  
17 record has been transmitted to DOL to date, and  
18 several others will be sent soon. Obviously we  
19 all want this number to begin to increase  
20 rapidly.

21           From the outset, a key element of our plan to  
22 conduct a large volume of dose reconstructions in  
23 a careful but timely manner, and return these  
24 cases to DOL in a form appropriate for final  
25 adjudication, has involved awarding a substantial

1 contract for support across the entire range of  
2 activities required to complete work on a claim.  
3 The success of this contract partnership is  
4 essential to the success of all of our efforts on  
5 behalf of claimants, so we're proceeding  
6 carefully and thoughtfully to ensure that we  
7 select a contractor that has the resources,  
8 skills, and experience to handle a large number  
9 of claims in a timely and scientifically rigorous  
10 manner. We intend to establish and manage this  
11 contract such that OCAS, our claimants, and the  
12 public can be confident in the fair and timely  
13 treatment of all claims.

14 We're nearing the end of this competitive  
15 procurement process, and I believe I speak for  
16 everyone at OCAS when I say we're very eager for  
17 the arrival of this much-needed contract support.  
18 Actually, just as an update, we expect the best  
19 of the final offers from the technically  
20 acceptable proposers on the 18th of July.

21 As you probably know, we make it very easy  
22 for claimants to contact us, and they do so. The  
23 number of phone calls received at OCAS has  
24 increased substantially each quarter as we  
25 receive more and more claims. We are currently

1 receiving an average of 40 phone calls per day,  
2 which really keeps us connected with the claimant  
3 concerns and issues, and motivates us to continue  
4 our efforts on their behalf.

5 Our web site, as I hope you'll agree, is an  
6 unusually rich source of information on this  
7 program, and it also serves as a channel through  
8 which claimants can contact us. We've received  
9 nearly 300 claim-related e-mails, and responded  
10 to every one of them within 24 hours.

11 So with that, I thank you for your attention,  
12 and I'll try to answer any questions you might  
13 have.

14 **DR. DEHART:** Roy DeHart. The question I have  
15 regards the telephone interviews. Those are  
16 rather extensive, and you've had a rich period  
17 here this third quarter to conduct those. Is  
18 there anyone here that can talk to the response  
19 of the individuals you've been calling on those  
20 interviews, survivors as well as the individuals?

21 **MR. SUNDIN:** Well, I've not actually  
22 conducted an interview myself. You're right, it  
23 is an extensive interview. I think we are  
24 getting reasonably good information from Energy  
25 employees, less detailed information, as you

1 might expect, from survivors. But of course, the  
2 questionnaire is designed to be less demanding  
3 for those survivors.

4 Jim, I don't know if you wanted to add to  
5 that?

6 **DR. NETON:** Yeah. This is Jim Neton.

7 It's been a fairly encouraging process thus  
8 far. We've been getting good feedback.  
9 Claimants are very responsive. We do mail out in  
10 advance of the interview a template of the  
11 questionnaire that the people will be responding  
12 to, so it gives them a heads-up, a week or so to  
13 review and refresh their memory about some things  
14 that happened in the distant past.

15 Dave's right, survivor knowledge is much less  
16 complete than the workers', but we do take names  
17 of coworkers at that point and will follow up, if  
18 necessary, with coworkers of that person to fill  
19 in the details.

20 In many cases we don't really flesh out the  
21 record much greater, but there's been some really  
22 good surprises in there where people will bring  
23 forth some information that will make a  
24 difference in the dose reconstruction. So by and  
25 large, I think it's been a worthwhile process.

1           We have not taken as long as -- well, they've  
2 taken about what we thought it would take. The  
3 average interview is running about an hour,  
4 although I think our record right now is well  
5 over four hours, so it varies. But it's been a  
6 very encouraging process thus far.

7           Larry just reminded me that we have run into  
8 some issues with classified interviews, and we've  
9 dealt with that in an appropriate manner. A  
10 number of these workers have in the past had  
11 security clearance, Q-cleared classifications.  
12 We make arrangements on those cases to conduct  
13 the interview in accordance with the rules and  
14 requirements surrounding that, and that is we  
15 actually will do the interview in a Department of  
16 Energy facility that is cleared for  
17 classification. A (inaudible) classification  
18 officer reviews the interview notes after the  
19 interview is complete, and we use that process.

20           So we've done two in that manner thus far,  
21 and it's worked really well. We're trying to  
22 keep the number of classified interviews down.  
23 We feel by and large most of these people do not  
24 need to share classified information for us to  
25 complete an adequate dose reconstruction, but at

1 least in two instances thus far -- we have a  
2 third one coming up, I believe -- they believed  
3 there was sufficient classified information that  
4 was needed to be brought forth to complete the  
5 interview.

6 **DR. MELIUS:** As I understand it, you're going  
7 to award -- you hope to award the contract for  
8 dose reconstruction later this month, and  
9 there'll be some time period getting the  
10 contractor then up and working. Have you got any  
11 projections as to how this will affect your  
12 ability to complete dose reconstructions, and  
13 what the time table will be to deal with the long  
14 backlog of dose reconstructions that will need to  
15 be done?

16 **MR. SUNDIN:** Well, first of all, I'm not  
17 absolutely sure that, given the best and final by  
18 the 18th, that we'll have a contract award on the  
19 30<sup>th</sup>, because there's a negotiation process. But  
20 having said that, I think we're close to getting  
21 the award. We'll continue to do dose  
22 reconstructions using our in-house staff until  
23 the contractor comes on board, obviously. But  
24 you're well aware that that -- what our capacity  
25 is using in-house staff.

1           The scope of work for this contract calls for  
2 a very ambitious start-up period. And that's  
3 going to be one of our very high priorities, is  
4 that there's not a long learning curve, to the  
5 extent that we can continue to remind this  
6 contractor that this contract calls for certain  
7 deliverables within 30 days of start-up. We  
8 intend to get them pointed on the task and going  
9 just as soon as possible. So it'll be a quick  
10 start-up, and hopefully making a lot of good  
11 progress against a considerable backlog.

12           **DR. MELIUS:** I guess my question is have you  
13 made any projections as to when you would catch  
14 up with the backlog? Say you have the contractor  
15 going September 1st -- whatever, some arbitrary  
16 date in the next few months -- then where does  
17 that put you in terms of dealing with the backlog  
18 of cases as well as, what, the 15,000 sitting  
19 over at DOL waiting to come over? I guess that's  
20 one question, and then I have a follow-up to  
21 that.

22           **DR. NETON:** I think I can answer that. The  
23 contract is written so that the contractor will  
24 have sufficient surge capacity to handle backlog  
25 volume. We have a requirement in the contract

1 that they bid to performing 8,000 dose  
2 reconstructions in the first year of operation.  
3 So at this point, it looks like that was a pretty  
4 good guesstimate going in, that there may be  
5 around 8,000 claims to process in the first year,  
6 maybe even slightly less than that. And so as  
7 best I can tell you is that within the first year  
8 of the contract all this backlog should be  
9 completed.

10 **DR. ZIEMER:** Follow-up question?

11 **DR. MELIUS:** Then -- actually two separate  
12 questions. One is that -- if I make sure I  
13 understand this right -- is that then that's  
14 8,000 a year plus whatever you can do in-house,  
15 we're talking about a two-year time period,  
16 roughly, if all those 15,000 or so over at Labor  
17 come over to NIOSH?

18 **DR. NETON:** Well, all the 15,000 haven't  
19 arrived at NIOSH yet. All I can say is -- well,  
20 it's 8,000 in the first year, although the  
21 contractor does have -- we do have -- we can  
22 request that they increase their capacity to  
23 handle whatever volume comes our way. Now  
24 whether they can handle 15,000 in a very short  
25 time period, I don't know. But it's certainly in

1 the scope of the contract to add dose  
2 reconstructions essentially as the volume  
3 increases. I really don't know what percent of  
4 those 15,000 that are out there are going to end  
5 up here.

6 **DR. MELIUS:** Then my other related question  
7 is what do you see as being the sort of rate-  
8 limiting step in trying to deal with that large  
9 backlog, whatever the number may be? We don't  
10 know obviously what that is. Is it going to be  
11 completing the dose reconstructions, or is it  
12 going to be getting information, the dose  
13 information from DOE? Because there's got to be  
14 some limitation on the capacity for the  
15 individual sites to respond.

16 **DR. NETON:** That's correct. Right now  
17 obtaining the information from DOE is a limiting  
18 step, but it really depends upon the case. We  
19 have a number of cases that we have sufficient  
20 information, they can go through very quickly.  
21 There are always going to be those difficult  
22 cases that are out there that are going to take  
23 much longer than we would like. But right now,  
24 obtaining adequate information on each claimant  
25 to complete the dose reconstructions is going to

1 be the limiting step.

2 **DR. ZIEMER:** Sally.

3 **MS. GADOLA:** My question has to do with  
4 basics. And I am sure that you've learned a lot  
5 while you've been doing the dose reconstruction,  
6 but I haven't seen it recorded anywhere. And I'd  
7 like if someone could address such basic  
8 questions as who actually recorded dosimeter  
9 readings, how were they kept, how were they  
10 transferred when employees transferred from plant  
11 to plant? If an employee thought that they were  
12 sick from radiation and they questioned this,  
13 were they able to obtain dose records? And if  
14 those records are kept the same in all the DOE  
15 plants, and have you noticed a big difference in  
16 the subcontractors and the various DOE plants?

17 I know those are a lot of questions, but I  
18 feel like we need to somehow record the actual  
19 basis before we get into the more complicated  
20 reconstruction.

21 **MR. SUNDIN:** If I understand, we don't have a  
22 large number of completed dose reconstructions,  
23 obviously. We've got several underway. But I  
24 think you're point's a good one, at some point,  
25 when we've done a few of these and gotten to the

1 end, to look back and see what we can take from  
2 that and learn, and apply it to those that still  
3 remain to be done.

4 Is that sort of the sense of your --

5 **MS. GADOLA:** I want to know who is really  
6 responsible for recording them, and who was  
7 taking a look way back when to make sure that the  
8 employees were not receiving too much radiation.

9 **DR. NETON:** Well, NIOSH is doing that. We  
10 are developing what we call the site profiles for  
11 each of the sites. We requested monitoring --  
12 not only do we request the monitoring information  
13 for the individual, but we've made a separate  
14 request for general information going back from  
15 the beginning of the site to document the  
16 radiation monitoring programs, what type of  
17 samples were taken, what the capabilities of  
18 their external monitoring devices were, and those  
19 type things.

20 We are assembling them and developing a  
21 database. All these things are electronically  
22 scanned, and then we derive secondary databases  
23 from them and profile these sites. We're working  
24 on that. I think we have about information on  
25 eight or ten sites right now. It's put on our

1 intranet. We don't have it out there for the  
2 public on our web site, although I suspect that  
3 that could happen if it was desired.

4 The other answer to your question, I think,  
5 is much of this is documented when we perform a  
6 dose reconstruction. It's an individual -- much  
7 an individual basis type thing, depending on when  
8 the person worked, basically, as you would think.  
9 And each dose reconstruction we take and we  
10 discuss which records were available, and why we  
11 used or did not use those records, and what the  
12 adequacy of them were for performing the dose  
13 reconstruction. That would be hard to get your  
14 handle on because they're individuals, but  
15 possibly when the Board undertakes its review of  
16 our dose reconstructions that may come out from  
17 that process.

18 **MS. GADOLA:** Thank you.

19 **DR. ZIEMER:** Sally, I might add a comment to  
20 that. In the early days of the AEC, and actually  
21 to some extent now, the individual laboratories  
22 have, perhaps intentionally, been made to develop  
23 a "not invented here" syndrome, where each one  
24 does its own thing. And so you see very  
25 different dosimetry schemes, it's not one scheme

1 for the DOE or for the old AEC. Oak Ridge had  
2 its own film badge system, Hanford had its,  
3 Savannah River had its. There are similarities,  
4 of course, and there was exchange of information.  
5 But if you look through those old records -- I  
6 have -- and there are differences in each case.

7 So you have to look at it certainly site by  
8 site. In many cases there are pretty good  
9 records as far as from a health physics point of  
10 view. But how far back you have to go before you  
11 would say they're pretty fuzzy, I think that'll  
12 come out as things develop. But even today you  
13 don't see that consistency from one lab to  
14 another, because the labs like to do their own  
15 thing. And to some extent they were encouraged  
16 in the past to do that. There was kind of a --  
17 almost a competition encouraged between the labs,  
18 and certainly in the early days, and that has  
19 carried forth.

20 Other questions or comments?

21 Yes, Sally.

22 **MS. GADOLA:** I appreciate all that you've  
23 done, and I appreciate from working some with  
24 NIOSH and with OSHA in the past and understanding  
25 their desire to give accurate, honest

1 information, and also realizing the difficulty --  
2 I'm talking about my experience in working in  
3 other plants, not DOE plants, and also working  
4 with people that were very well-meaning that  
5 worked in safety, but also did not have adequate  
6 training. Therefore, I appreciate the magnitude  
7 of this task of trying to be accurate, trying to  
8 give good information, and also realizing that  
9 when employees in other plants have questioned  
10 levels -- like for chemicals -- that often those  
11 records were lost, those records had been  
12 altered, and from my own personal knowledge  
13 knowing that some of the people that were  
14 responsible had lapses of memory.

15 And that's why I think it's important that as  
16 a Board that we just question it and document it,  
17 and appreciate the difficulty of really obtaining  
18 scientific, accurate, very basic information.  
19 And I appreciate all that you have been doing,  
20 and I think NIOSH understands the difficulty of  
21 that. Thank you.

22 **MR. GRIFFON:** Mark Griffon. Just to follow  
23 up on this line of questioning, saying the  
24 limiting factor was getting information from DOE,  
25 I think last meeting we asked about a Memorandum

1 of Understanding between NIOSH and DOE. Do you  
2 have a status on that? Did I miss that maybe?

3 **MR. SUNDIN:** I did speak to that. We have  
4 had a number of exchanges with our counterparts  
5 in DOE, have arrived at some shared understanding  
6 on certain issues, and identified others that we  
7 may want to table. But I believe we're close to  
8 having a document which both Departments can sign  
9 on to. The discussion process itself really has  
10 value, I think, in negotiating MOUs, which are of  
11 course not legally-enforceable documents. In  
12 that respect I think there's been a lot of good  
13 interchange and exchange of views between HHS and  
14 DOE. I can't give you an exact date when we  
15 might have a signed agreement.

16 **DR. ZIEMER:** Jim.

17 **DR. MELIUS:** Yeah, to follow up on that  
18 question, it would seem to me that in the MOU  
19 there would be at least two sort of deadlines or  
20 schedules that would be important.

21 One is sort of for routine responses, where  
22 it's straightforward and getting records that are  
23 available, and it's just a question of sort of  
24 the time at the facility to find the records, get  
25 them in a form that they can be sent to NIOSH.

1 And you still want that to occur within a certain  
2 time period or it'll back up the entire process.

3 The second one would be that if -- for harder  
4 to find records, or where there's questions  
5 whether records are available at all, or whether  
6 even monitoring was done on an individual. And  
7 that may take longer, but if you don't have some  
8 sort of a deadline or schedule to deal with that  
9 it would seem to me it would back up the whole  
10 process, and you have people that would be  
11 waiting for months or years to get even into the  
12 dose reconstruction phase.

13 Is there consideration in the Memorandum of  
14 Understanding for dealing with both of those  
15 issues?

16 **MR. SUNDIN:** There is, Jim. I share your  
17 basic observation. That has been a major point  
18 of discussion during our negotiations -- if  
19 that's the right word -- around this MOU. So I  
20 don't know exactly how we will come out on that,  
21 but we want to make it clear that both agencies  
22 share a commitment to timely satisfaction of  
23 information requests, with acknowledgement that  
24 there are certain requests which will require  
25 more time. So that is a central discussion point

1 in the MOU.

2 Any other questions?

3 **DR. ZIEMER:** Additional questions?

4 (No responses)

5 **DR. ZIEMER:** There appear to be no additional  
6 questions at this time. Dave, you'll be here --  
7 will you be here throughout the meeting, or just  
8 today?

9 **MR. SUNDIN:** Yes, I'll be here both days.

10 **DR. ZIEMER:** Good. So if additional  
11 questions arise, then -- or other staff members  
12 could also address some of these things.

13 Might I ask, just before our next speaker,  
14 Larry, would you just take a moment and introduce  
15 all of the other staff members who are with us  
16 today just for the record? Many of them we've  
17 met before, but I'd like to ask that they be  
18 introduced.

19 **MR. ELLIOTT:** Surely. We have with us today  
20 -- from OCAS we have Jim Neton, who you've heard  
21 earlier this morning, is the health science  
22 administrator; and my staff, Russ Henshaw, who  
23 has been presented to the Board before, an  
24 epidemiologist on OCAS; Ted Katz, who's a policy  
25 analyst within NIOSH; Dave Sundin, you just met

1 and heard from; and Cori Homer, who's probably  
2 dealing with some issue administratively right  
3 now. And we have Mary Armstrong, who's Office of  
4 General Counsel assigned to NIOSH; Liz, Elizabeth  
5 Homoki-Titus, who I don't see in the room right  
6 now, another attorney assigned to us from the  
7 Office of General Counsel. I think that's all  
8 the staff members from NIOSH.

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

10 And then before we hear from the  
11 representative from Department of Labor, I would  
12 like to also take this opportunity to have  
13 members of the public or other guests introduce  
14 themselves. We generally do this sometime during  
15 the morning, not only for the record, but just so  
16 that we have an awareness of who is with us this  
17 morning. So I'm just going to take a minute now,  
18 and if you're not one of the staff members that's  
19 been introduced but are an observer or member of  
20 the public, just if you would please introduce  
21 yourself and indicate who you represent, or  
22 whether it's yourself or a group. We can start  
23 in the back there.

24 **MS. KIEDING:** I'm Sylvia Kieding, and I'm  
25 with Pace International Union.

1           **MS. ARMSTRONG:** I'm Mary Armstrong, OGC.

2           **MR. TINNEY:** Joe Tinney with SAIC, and a  
3 former DOE employee and union contractor. Spent  
4 two and a half years with (inaudible).

5           **MR. TABOR:** I'm Bob Tabor. I've been here  
6 before. I'm from Cincinnati, the Fernald site,  
7 Fernald Atomic Trades & Labor Council.

8           **MR. SCHOFIELD:** I'm Phillip Schofield. I  
9 spent 21 years at LANL as a radiation worker.  
10 I'm here to represent Los Alamos POWs. I was put  
11 out on (inaudible) in '96.

12           **MR. MANSANARES:** I'm Bob Mansanares. I'm  
13 with the Department of Labor.

14           **MR. MALITO:** I'm Ray Malito, the manager of  
15 the Energy Resource Center here in Denver.

16           **DR. BISTLINE:** Bob Bistline. I'm with the  
17 Rocky Flats Field Office in Department of Energy.  
18 I've been at Rocky Flats for 36 years, on a  
19 contractor site with DOE.

20           **MS. PRESLEY:** Louise Presley, observer, wife  
21 of Board member Robert Presley.

22           **MR. KOTSCH:** Good morning. My name is Jeff  
23 Kotsch. I'm a health physicist with the Energy  
24 Compensation Group, Department of Labor, back in  
25 Washington.

1           **MS. LEVINE:** I'm Sonya Levine from the  
2 Department of Labor, Office of the Solicitor,  
3 from Washington.

4           **DR. ZIEMER:** Thank you very much.

5           Let's proceed with the Department of Labor  
6 program status report, Robert.

7           **MR. MANSANARES:** Good morning. My name is  
8 Bob Mansanares. I'm District Director for the  
9 Department of Labor's Energy Compensation  
10 District Office here in Denver.

11           I want to thank you, Mr. Ziemer and Mr.  
12 Elliott, for having me, for asking me to come  
13 here and speak to you and give you a progress  
14 report for -- I do not say EEOICPA; I say Energy  
15 Compensation. The EEOICP is long enough in  
16 itself, and I feel that Energy Comp is  
17 understood.

18           First of all, let me say that I'm here, and  
19 I'm very happy to note there are two DOL  
20 colleagues here. I was feeling somewhat  
21 overwhelmed this morning, and then I realized I'd  
22 seen those faces before, but I wasn't quite sure  
23 where. And it really is nice to know there are  
24 colleagues here. So if I misstate a legal point  
25 of view, just raise your hand and advise me, and

1 I will retract and we will correct.

2 And the other thing is, as I understand it  
3 this is the Advisory Board's first meeting in  
4 Denver, and of course, welcome to Denver. You're  
5 going to find Denver is a very inviting place.  
6 We have a tax structure that says to us, if we're  
7 smart Coloradians, welcome, visitors, and do  
8 spend your evenings profitably on behalf of  
9 Colorado by shopping and taking in the sights.

10 I think that most of you know the program  
11 provides compensation for persons who have become  
12 ill as a result of working at DOE facilities and  
13 certain vendors and subcontractors. Again,  
14 uniformity in the development and the payment of  
15 benefits is the protocol that I'm sure the  
16 Congress had in mind when they started thinking  
17 about Energy Comp and the Department of Labor  
18 delivering benefits in terms of administration.

19 These are the benefits that are payable:  
20 Covered medical costs; lump sum is \$150,000 to  
21 the employee or the eligible survivor; Radiation  
22 Exposure Compensation, or RECA benefits, Section  
23 5 recipients receive an additional \$50,000. Of  
24 course, that's in addition to the \$100,000 that  
25 they receive from the Radiation Exposure

1 Compensation Act.

2 And in Denver that's what we handle  
3 principally, is the Radiation Exposure  
4 Compensation Act claims. We'll be showing you a  
5 pie chart here, and a significant part of the  
6 claims or benefits paid through that pie chart  
7 are the RECA claimants. These are claimants that  
8 were established for this entitlement under  
9 Section 5, then we would provide \$50,000 to the  
10 employee or the survivor; and if it's the  
11 employee, then they also have the entitlement for  
12 the covered condition that this provision or this  
13 Act provides for.

14 The four conditions that are covered are  
15 cancer, chronic beryllium disease, beryllium  
16 sensitivity, silicosis, and the illnesses under  
17 Section 5 of the RECA.

18 Program highlights are that it was enacted  
19 October 30th, 2000. It went effective July  
20 31st, and Secretary Chao presented the first  
21 payment on August 9th. Amendments were enacted  
22 to the provisions on December 28th, 2001.

23 This is the overall organization chart, if  
24 you wish, or description of how services are  
25 delivered across the United States. We have four

1 District Offices. Federal staff number 122 --  
2 this slide is somewhat dated; that number is a  
3 little bit larger, but not by much. Contractor  
4 staff are 26, and then there's a break-out.  
5 National office staff, 25 federal staff,  
6 including the director; contractor staff, nine.  
7 And then groups that fall within the  
8 administration are Director, Automated Data  
9 Processing, Policy and Procedure, Outreach and  
10 Training, and Final Adjudication Branch.

11 So the Director's Office is basically Turcic  
12 and Roberta Mosier and their staffs. Automated  
13 Data Processing are Jerry Delo, and the ADP  
14 staffs that work with him to set up systems.  
15 Policy and Procedure are Rachel Leiton, who is  
16 the branch chief there. Outreach and Training  
17 are generally headed up by Carol Bronowicz, and  
18 many of you know Larry Hoss, and their staffs  
19 that provide outreach. Final Adjudication Branch  
20 is Luann Kressley, is headed up by Luann  
21 Kressley. Each one of these Final Adjudication  
22 or the National Office FAB, in fact, also has a  
23 presence in the regions. The local FAB is headed  
24 up by Joyce Terry.

25 This will give you a jurisdictional idea,

1 Colorado in blue, the 15 states that we provide  
2 services for. And then you have Cleveland up in  
3 green, Jacksonville depicted in red, and Seattle  
4 in yellow.

5 These are the participants in the claims  
6 process. These are our constituents: NIOSH;  
7 medical providers; Social Security Administration  
8 for verification of employment; claimants who are  
9 filing, both the survivors and as employees;  
10 corporate entities who provide us with  
11 information as to employment and if they have  
12 health records or health information, we're  
13 provided that; the Department of Energy; and the  
14 Department of Justice, all feed into the claims  
15 process that is handled by the Department of  
16 Labor.

17 This is probably a number -- these are  
18 numbers that you probably will be interested in.  
19 Effective June 13th, total number of claims  
20 received is just under 30,000. Total cancer  
21 claims numbered 19,000. Total beryllium  
22 sensitivity are at about 1,019. CBD claims are  
23 1,010. Silicosis, 534. RECA claims are 3,512,  
24 and other claims are about 4,496.

25 This is the program statistic as of June

1 13th. Claims processed with final decision --  
2 that's a decision by the Final Adjudication  
3 Branch -- approvals, 3,531; denials, 1,277.  
4 Claims processed with recommended decisions --  
5 these are decisions by the Energy Comp District  
6 Offices which have not become final, but are sent  
7 to the FAB for review as a final decision -- the  
8 approvals were 4,176, denials were 3,262. Cases  
9 awaiting employment verification number about  
10 5,300. Cases sent to the NIOSH are 4,914.  
11 Payments issued are 3,170, and if you recall, I  
12 said that the RECA comprises the biggest majority  
13 of this payment, at about 1,200. And amount of  
14 compensation paid, well, that's a big number,  
15 \$237 million. And of course, again, that was as  
16 of June 13th.

17 This is just -- this is a break-out of the  
18 same figures you saw in the previous slide, to  
19 give you a visual and an idea as to where the  
20 number of claims are outstanding, listed at  
21 10,903.

22 This is the last slide. As of June 13th, the  
23 yellow indicates overall acceptance of claims.  
24 These are final decisions, not proposed. You can  
25 see there's 73 percent acceptance, 27 percent

1 denial. And again, of the accepted cases, more  
2 than likely the majority of these are Radiation  
3 Exposure Compensation Act cases, which total  
4 payment of \$50,000. It can be broken up by  
5 survivorship. As the District Director in Denver  
6 I authorize payment on these, and it's not  
7 uncommon for me to authorize payments of about  
8 \$4,000 to \$6,000 for anywhere from four to eight  
9 siblings of survivors when there is no surviving  
10 spouse.

11 So that is the status of our program at the  
12 present time, and I'm willing to take questions.  
13 I'm sure some of these slides may need  
14 clarification.

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

16 Let's open it for questions then.

17 Roy DeHart.

18 **DR. DEHART:** Just a comment on how you're  
19 doing the job validation. There have been  
20 complaints that people who have been employed in  
21 the environment for 20 to 30 years are having to  
22 go through their files personally, their own  
23 files, to send information -- I'm from Tennessee,  
24 so it would be Jacksonville?

25 **MR. MANSANARES:** That's correct.

1           **DR. DEHART:** Could you tell me why that's  
2 necessary, why there isn't records available on  
3 these people who have been employed in the  
4 nuclear business?

5           **MR. MANSANARES:** I think that the experience  
6 as to -- this, for us, as a claims manager, would  
7 be factual evidence. And for anyone who's  
8 involved in claims development for factual  
9 evidence, which would be comprised of employment  
10 records or marriage certificates, children's  
11 birth certificates, and things of that nature, I  
12 do not personally understand why some of these  
13 records are not available, other than the  
14 explanations that are given me by the Department  
15 of Energy and others that are involved in the  
16 record retention process. I think that the  
17 experience of the claimant depends and varies as  
18 to where in the country they're worked and for  
19 whom they worked.

20           We use alternative procedures for  
21 establishing employment verification. If that  
22 primary evidence is not available from the  
23 employer, there are secondary and tertiary pieces  
24 of evidence that we can use to establish the  
25 person's presence or employment at those sites.

1 And they can vary from -- oftentimes birth  
2 certificates will indicate the occupation of a  
3 parent. Many times there are clippings or  
4 newspaper notices that individuals retain because  
5 they were involved in a process or in a success  
6 that a particular facility experienced. So these  
7 are other types of evidence that we will use.

8 Also, if you noticed in the constituents to a  
9 claim slide here, we had the SSA, the Social  
10 Security Administration, from 1938 to the present  
11 time, oftentimes with a list of the individuals  
12 working for a contractor or vendor at a specific  
13 location, and we would use that information. And  
14 of course, we will also go to the affidavit. As  
15 long as the affidavit has a value that can be  
16 established and it is supported by other evidence  
17 in the file, then we will make a finding of  
18 employment and proceed as is necessary.

19 But yes, we are experiencing at some sites --  
20 some of the District Offices are experiencing  
21 difficulty in obtaining records. Although the  
22 initiative and the efforts of the NIOSH, for  
23 instance, they're finding records that previously  
24 we were told were not there. But as a result of  
25 their on-site inspections and their interactions

1 with the records keepers, they've turned up  
2 records that we're able to use in Jacksonville,  
3 Denver, Cleveland, and Seattle.

4 Did I answer your question, or did I just  
5 waltz all the way around it?

6 **DR. DEHART:** No, I think you answered it.

7 **MR. MANSANARES:** Somewhere, okay.

8 Yes, sir.

9 **DR. MELIUS:** What is the rate of claims  
10 coming in now?

11 **MR. MANSANARES:** It varies by District  
12 Office. Initially in Denver -- and I can talk to  
13 Denver -- I think we have about 4,400 claims in-  
14 house at the present time. We have a staff of  
15 about 15 claims examiners at the present time,  
16 and many of those are recent hires. But I would  
17 say that prior to March we were running -- it  
18 varied 300 to 400 claims. Last week we had 89  
19 claims. It's been running less than 100 claims  
20 per week at the present time for Denver.

21 **DR. ZIEMER:** No further questions?

22 (No responses)

23 **DR. ZIEMER:** Okay, thank you very much.

24 **MR. MANSANARES:** Thank you, sir.

25 **DR. ZIEMER:** The next item on our agenda is

1 the report of the dose reconstruction workgroup,  
2 and that was -- the workgroup was headed by Mark  
3 Griffon.

4 And Mark, if you would, before you get into  
5 your slides, go ahead and introduce the members  
6 of the workgroup, then proceed.

7 **MR. GRIFFON:** Thank you. Yeah, I was going  
8 to -- I didn't have a slide on the members of the  
9 group, but the members of the group, going around  
10 the table, Genevieve Roessler, Roy DeHart, Bob  
11 Presley, Rich Espinosa, and Jim Neton as our  
12 NIOSH representative on the working group.

13 After I introduced the members, I also wanted  
14 to say it was a process. We ended up having two  
15 conference calls as a working group. The first  
16 conference call we had, we did generate minutes  
17 from that and we sent them around to the Board,  
18 and I believe they got posted on the web site. I  
19 haven't checked that.

20 The second meeting of the working group was  
21 actually last week, so rather than generate  
22 minutes we took the time to generate this  
23 presentation. And we ended up having pretty good  
24 discussions on some issues. I think we ended up  
25 with some recommendations. I think we need to

1 flesh out some other issues to end up in the form  
2 of a recommendation actually, and we'll get to  
3 that as we go through the slides.

4 The charge was to develop options to review  
5 the scientific validity and the quality of the  
6 NIOSH dose estimation and dose reconstruction  
7 efforts, and this comes right from the statute.  
8 The four main issues that we ended up, or I  
9 consolidated these into four main topics that we  
10 discussed, was who would conduct the review, how  
11 the selection of cases -- how would we select the  
12 cases, the protocols that we would use for the  
13 review and sort of the scope of work for the  
14 Board to review the cases, and then the reporting  
15 out of the reviews that the Board does to the  
16 public and elsewhere.

17 Who will conduct the review: We talked about  
18 some different options, either with independent  
19 experts along with Board representation, and this  
20 was probably something that we agreed the most on  
21 as a recommendation. We felt pretty strongly  
22 that we needed an independent panel with  
23 independent experts, but we also needed Board  
24 representation and Board oversight. I think we  
25 noted that the Board is ultimately responsible

1 for these reviews, so the Board would certainly  
2 have to maintain oversight on this process.

3 As we were developing that option we talked  
4 about several issues: Whether these should be --  
5 whether we should have individual experts,  
6 contractors, or a consortium, and it might be a  
7 consortium of several contractors; the size of  
8 the panel, what was a workable size; the  
9 availability of independent experts. The issues  
10 that came out here was that as NIOSH is in the  
11 process of hiring a contractor to do the dose  
12 reconstruction, we all know that there's a  
13 limited pool of experts in this area. So we just  
14 thought that may really be an issue here. And  
15 then the selection, which was more of who and how  
16 do we do the selection process. And the nature  
17 of the panel meetings, should the independent  
18 expert panel meet, should they have public  
19 meetings? They obviously have to get their work  
20 done, but there also has to be a level of  
21 transparency of what that panel's doing.

22 So along the lines of the expertise,  
23 individual experts, contractor or consortium, we  
24 talked about the issue of they had to have a wide  
25 variety of expertise to review the cases.

1 Sometimes there's individual experts out there  
2 that really their strength lies in internal  
3 dosimetry, and they're less skilled in reviewing  
4 external radiation dose cases. Or they may have  
5 worked in certain sectors of the nuclear industry  
6 and not be familiar with reactor exposures and  
7 things like that. So we thought that was one  
8 criteria we needed to discuss further.

9 Also, the second one, important to have  
10 credibility to do objective work. And this again  
11 was our attention to the concern that the public  
12 has to have faith in this Board as doing an  
13 independent review. And along with transparency,  
14 we thought it was important to have maybe -- the  
15 panel have representation that maybe was outside  
16 the box a little bit. If it was the same -- if  
17 it was perceived as being the same -- this  
18 overlaps a little bit with the next item, which  
19 is the conflict of interest -- but it was if  
20 there was a perception that the same people were  
21 reviewing that have always reviewed the cases and  
22 always done the dose work at these sites, then  
23 the claimants on the other side, especially the  
24 rejected claimants, may say, of course, we  
25 certainly saw that one coming. So we think that

1 -- we thought that there might be a use in having  
2 expertise that was sort of outside the box that  
3 could be critical of the model assumptions, et  
4 cetera. And if after all that the cases stood  
5 up, then they have more credibility actually.

6 The size of the panel and the availability of  
7 the experts: One model we turned to in our  
8 review -- and Jim Neton provided us some  
9 documentation, a GAO report which I think was  
10 sent around to the whole committee. And I  
11 followed up on the NAS folks, and there's  
12 actually on their web site they have some  
13 documentation of their scope. They are required  
14 to do a review. They have a NAS subcommittee  
15 headed, chaired by John Till, and I think  
16 currently they have nine experts on this panel.  
17 That was one model we looked at. We're not sure  
18 that's the right number. That's the model  
19 they're using. Some folks thought that was a  
20 little large and may be unwieldy, actually, but  
21 it was something we turned to. And then again, I  
22 mentioned the small pool of experts that may be  
23 left available for this.

24 The selection, the Board felt pretty strongly  
25 that -- or the working group felt pretty strongly

1 that the Board should be responsible for the  
2 selection of who. And Jim Neton, before I  
3 overstep my legal bounds here, I'm going to ask -  
4 - I think NIOSH would actually have to do the  
5 contracting process. I don't want to get this  
6 wrong, but we felt pretty strongly that the Board  
7 should make the determination and decisions on  
8 who, whether it be individuals, contractors, or a  
9 consortium. The Board should have the input on  
10 that, and NIOSH can work out how to do the  
11 contracting on that.

12 As far as meetings, we felt first that the  
13 panel should report to the Board. Again, this  
14 goes back to the Board being responsible for  
15 these reviews. And again, we emphasized again  
16 and again, this has to be a transparent process.  
17 So somewhere -- and that's, again, those reports  
18 back to the Board would be public meetings, and  
19 the public would be able to see what's going on.

20 Another recommendation was the workgroup felt  
21 that the Board should select the cases for  
22 review, and we felt also that we needed to have a  
23 stratified sampling of cases. I believe in the  
24 case of the VA it's more of just a random  
25 sampling. I'm not sure of that, but the way they

1 describe it on their web site it's a random  
2 sampling. But due to the nature of the DOE  
3 sites, we felt it behooved a stratified sampling  
4 strategy. And we talked about some parameters.  
5 These may not cover all, and I think this is an  
6 area where we may need to be -- give a more  
7 specific recommendation. But the site, the  
8 exposure type, cancer type, time period are some  
9 possible parameters that we may stratify on.

10 The number of cases, overall case load  
11 greater than 2.5 percent. We came on that number  
12 because we turned to this VA model. The VA has  
13 selected about 100 cases out of an overall of  
14 about 4,000, which is about 2.5 percent. And we  
15 thought -- we tried to hone in on a number, but  
16 we said, well, at least we think that it should  
17 be greater than 2.5 percent, the rationale being  
18 that we've got to have a stratified sampling, and  
19 that's going to create more cases that have to be  
20 reviewed. It seemed to be a reasonable answer to  
21 that. So we don't know the upper bound of that,  
22 but we think that it's probably going to be  
23 something greater than 2.5 percent of the cases.

24 Again, the workgroup agreed that the Board  
25 should establish the protocol for the panel. And

1 protocol and -- scope of work/protocol, I might  
2 say -- scope of work for the NAS review, we  
3 looked at the scope of work that was described  
4 for the NAS panel, and we discussed potential  
5 tasks for the scope of work and the type of  
6 review. I'll go into those a little bit here.

7           These are the -- some of these overlap pretty  
8 well with what was done on the -- what is -- I  
9 guess what was Congressionally mandated to the  
10 NAS as the scope for their review of the VA  
11 cases. I hope I got that right. The panel  
12 should determine whether or not the  
13 reconstruction of the dose is accurate. And the  
14 parenthetical point is important. I'm doing this  
15 for Jim Neton. He reminded me several times that  
16 accurate to the extent that it's good enough to  
17 determine eligibility. And I think that's an  
18 important point of this, because sometimes, as  
19 NIOSH has said, they may not have to be very  
20 accurate. If someone has really high doses they  
21 don't need to fine tune it that much. They  
22 trigger, they're in; it doesn't matter. And if  
23 they're very low, on the other side, they may not  
24 have to fine tune as much. So the panel should  
25 determine whether or not the assumptions,

1 individual case assumptions or assumptions that  
2 are applicable to groups of people, are credible.  
3 So that's the accuracy of dose estimate, the  
4 credibility of the assumptions.

5 The panel should determine whether or not the  
6 data from DOE or other sources is accurate. And  
7 the panel should determine whether or not the  
8 estimate of the dose is a reasonable estimate,  
9 and "reasonable estimate" being a term that was  
10 in the statute.

11 Now, the panel should determine whether or  
12 not data from DOE or other sources is accurate,  
13 that item generated a lot of discussion. We felt  
14 pretty strongly -- and this, I think, goes to  
15 Sally's points earlier, that in order to maintain  
16 transparency of this process and to give  
17 credibility to our review, we need to in some  
18 ways check that to make sure that NIOSH went  
19 back, and the data they got was good quality and  
20 was useful for -- was good enough for determining  
21 whether people were eligible. So now how we get  
22 there is another question, but we think that is a  
23 very important aspect.

24 And that sort of leads to this, too, which is  
25 this tiered review idea. The three methods of

1 review here are simplest to most complex or most  
2 extensive. And the initial review of the cases  
3 and the calculations, that will be just sort of  
4 looking at NIOSH's or the contractor's work and  
5 checking all the assumptions, checking the  
6 calculations, that sort of thing.

7 The next step is to check a little further,  
8 and on a certain number of cases you might look  
9 at quality of the data and how NIOSH decided, if  
10 there was inconsistencies, for instance, between  
11 personal interviews and the records, how did  
12 NIOSH rectify that, and how did NIOSH handle that  
13 in their reconstruction.

14 And then the third is even more extensive,  
15 where we actually want to see what was requested,  
16 what did NIOSH request from DOE, were all the  
17 records -- and I put "all" in parentheses, too --  
18 were all the records provided from DOE. And the  
19 question that was chased around by the working  
20 group was, well, how do you -- as it is by many  
21 researchers at the DOE sites, how do you know if  
22 all the data was reviewed if you don't know what  
23 all the data is? So it's a -- but we thought  
24 that is, again, an important point because of  
25 some people's concern about the DOE either

1           destroying records, destroying data, et cetera.  
2           We think that the Board should have some level to  
3           look into what kind of data is coming from the  
4           DOE, not just the secondary steps. So we felt  
5           that was an important point.

6           The review panel reports, the workgroup  
7           agreed that the panel must first report back to  
8           the Board, and then the panel reviews and the  
9           reports of panel activities, policies, and  
10          procedures should all be made available to the  
11          public in de-identified form, obviously. But  
12          that, again, is for the transparency for that.  
13          So that's the report out by -- I think that's it.

14          I just wanted to say the last thing -- I  
15          think the three areas that -- and we discussed  
16          this -- that we may, after discussion with the  
17          full Board here, we may want to go out tonight  
18          and fine tune three areas for more specific  
19          recommendations. One of them is the makeup of  
20          the panel, flesh that out a little better; also  
21          the selection of cases; and then the scope of  
22          work for this independent review panel. So I  
23          think we agreed that the panel would meet tonight  
24          if we needed to.

25          Did we agree, panel, or working group, I

1 mean?

2 (Affirmative nods)

3 **MR. GRIFFON:** Roy says as long as he gets ice  
4 cream.

5 **DR. ZIEMER:** Thank you very much, Mark. I  
6 believe, based on those comments and what you've  
7 just now suggested, probably it would be  
8 worthwhile if we got the initial feedback from  
9 the full Board and reactions, comments,  
10 suggestions that the committee could use to -- as  
11 they huddle tonight and refine this. And then we  
12 can revisit it tomorrow in perhaps in what we  
13 might call more final form, and see if the Board  
14 is ready to take formal action tomorrow or if  
15 further refinement is needed.

16 I think we're not under tremendous pressure  
17 to necessarily finalize it at this meeting,  
18 because we know that there's going to be a little  
19 time lag before cases are -- until there's a body  
20 of cases to be looked at. So we can be fairly  
21 deliberate, if necessary; but we want to move  
22 ahead, on the other hand, and be ready to hit the  
23 ground running.

24 So let's open it up at this point for  
25 questions, comments, and other reactions. I

1 think the subcommittee has done a very good job  
2 of thinking about the issues that have to be  
3 addressed, and we appreciate the input that  
4 you've given us here.

5 Okay, Tony.

6 **DR. ANDRADE:** Mark does a good presentation.  
7 I appreciate all of the work and the thoughts  
8 that you and the panel put together with respect  
9 to the -- the questions are very important  
10 questions that will face this panel, group, team,  
11 whatever you want to call it.

12 Let me start from the back end of my though  
13 process, and then I'll get into what might be  
14 considered a very quick straw man on the  
15 recommendations.

16 What would happen if this team were to  
17 somehow find a shortcoming, a potential  
18 shortcoming, a disagreement with a dose  
19 reconstruction activity, even if it was for a  
20 single individual, or perhaps the way those dose  
21 reconstructions were being conducted? Perhaps  
22 the answer's not available right now, but it's  
23 certainly one that's going to have to be  
24 addressed at some time.

25 My next statement is in the form of a

1 comment, and it's more along the lines of a  
2 recommendation that might be considered as a  
3 straw man for further discussion this evening.  
4 For the John Till group, my own personal  
5 experience has been a group that -- how shall I  
6 say -- it seeks to keep the maximum number of  
7 contractors employed. I would strongly recommend  
8 the following criteria for a team.

9         Number one, that we should consider no more  
10 than two relevant and independent experts. What  
11 I mean by relevant is, as you pointed out,  
12 experts that are familiar with the particular  
13 type of dosimetry that was conducted at a  
14 particular site. If it happened to be  
15 Washington, for example, you might want to have  
16 reactor experts, reactor health physicists.

17         Number two is that I think it would be  
18 beneficial to have at least one, and perhaps even  
19 two, Board members be members of that team, so  
20 long as they have no conflict with the operations  
21 of the site that is being reviewed. For example,  
22 I would recuse myself from any work that was done  
23 in review of work at Los Alamos.

24         And number three is that I would recommend  
25 that whatever panel is put together, that they be

1 allowed to conduct at least two reviews at two  
2 separate sites for that minimum number of reviews  
3 that you're talking about, for the following  
4 reasons: One is that a working team develops a  
5 relationship and a rapport, perhaps during the  
6 first experience they have, and they start to  
7 learn about what is important, what sort of  
8 records need to be considered and kept --  
9 alluding back to what Sally was talking about  
10 this morning. And it would be a tragedy to lose  
11 that experience if that panel is disempaneled  
12 without going back and approaching a different  
13 site with a whole different way doing -- that had  
14 a whole different way of doing business without  
15 this same type of approach, so that they can do  
16 an apples-to-apples comparison of the state of  
17 affairs at the two different sites.

18 So those are my comments for now.

19 **DR. ZIEMER:** Thank you.

20 Other comments?

21 Yes, Jim.

22 **DR. MELIUS:** Yeah, a number of comments.

23 I would agree with Tony. I guess number one  
24 is I think we need to get this review going as  
25 soon as feasible. It's not something we should

1 put off until we get enough numbers to sample  
2 from or whatever, whatever kind of plan we --  
3 tiered plan we develop. Because I think sort of  
4 the credibility of the process is important, the  
5 overall process is important, and we don't want  
6 to be in a position where we have to redo a bunch  
7 of dose reconstructions or whatever. And the  
8 credibility's particularly important at an early  
9 point in time in this process. So I think we  
10 ought to try to get as far as we can today, and  
11 then push NIOSH to get whatever we recommend  
12 implemented, doing that.

13 Secondly, I like the idea of sort of small,  
14 smaller teams making up a panel that reviews  
15 cases, and that they also review cases for more  
16 than one site so it's not just a site-specific  
17 panel. They may draw -- well, let me get to that  
18 in a second. But I think that might be a way of  
19 sort of keeping the process moving quickly,  
20 efficiently, and at the same time building some  
21 confidence and expertise. So I think that way of  
22 developing a panel may work, but any way we do it  
23 it's logistically complicated because of  
24 conflicts and availability of the appropriate  
25 experts.

1           Third, I think it is important, and Mark's  
2           comments, this whole issue is is all the data,  
3           available data or information or appropriate data  
4           and information, being considered in the dose  
5           reconstruction? I think that's going to be  
6           probably the major concern the claimants have,  
7           that, oh, I know there's other information that's  
8           being hidden that wasn't available, whatever. I  
9           think when we get to the special exposure cohort  
10          proposal from NIOSH, I think that is even --  
11          emphasizes and makes that even more important.  
12          Is all the data really being considered?

13                 So I think we need some way as part of this  
14          process of getting that information. And whether  
15          that'd be some way of accessing some people with  
16          long-term knowledge of the site, just to make  
17          sure that they -- NIOSH has considered all of the  
18          available information, or all the available or  
19          appropriate information is made available to  
20          them, I think is key. And I think whatever we  
21          can do to get that would really help with the  
22          credibility of the overall process. And that may  
23          have to be done a little bit separately than the  
24          group of experts who would do the dose  
25          reconstruction. At the same time it's got to be

1 tied to that, because I think you want to be  
2 looking for appropriate information, not just  
3 every piece of information that's not relevant to  
4 what is being done for this dose reconstruction.

5 **DR. ZIEMER:** Thank you.

6 Yes, Henry.

7 **DR. ANDERSON:** I guess I would agree that we  
8 probably need to get started fairly quickly. It  
9 would seem to me that as we move into meeting  
10 eight, nine, and ten or whatever, the activity of  
11 the Board will focus more and more on these  
12 reviews.

13 It would seem to me what we may want to do is  
14 rather than have a few Board members be on the  
15 panel, establish panels so that all Board members  
16 would either rotate on the panel or would be part  
17 of a separate panel. So we may -- I also agree  
18 that smaller numbers is probably more than  
19 adequate. So I would think in terms of setting  
20 it up so that a few Board members would not bear  
21 all of the work brunt, and that everybody would  
22 in fact be part of these panels so we'd have the  
23 experience of, when it comes back to the panel or  
24 the Board for final approval, that we'd all have  
25 worked through some of these individually but not

1 have to work through all of them. So that would  
2 be one.

3 The other is it would be interesting to see  
4 or maybe hear from the VA panel what's their  
5 protocol, maybe have them come at a meeting and  
6 just say what's been their experience, how do  
7 they do it. It seems to me we'll need a number  
8 of things. Being an epidemiologist, I would look  
9 in terms of wanting to analyze data, looking at  
10 perhaps case-control things to look at, what are  
11 the parameters, perhaps even datasets, that might  
12 well predict who is accepted and who isn't  
13 accepted, over and above what the actual  
14 exposures were. It may well be the quality of  
15 the data may become very obvious in one side or  
16 the other.

17 So I would think we're going to have to have  
18 some check sheets of what's there, and then the  
19 validation process. That may be something  
20 contractors could do. But I would think we need  
21 to have a protocol. We need to have a data  
22 collection system so that as we get these we'll  
23 be able to see, and you may identify that in this  
24 one, gee, look, they had that data; and this one  
25 is missing that data, and is that because they

1           couldn't find it, or what is the issue, so we  
2           kind of have all-encompassing, all possible  
3           sources that you'll get through all of the  
4           systems, and then we'd want to check to see does  
5           this particular case have those. And that would  
6           lead us to the question, if they don't, was it  
7           not collected, or was it -- is it missing? And  
8           that might be one way to look at some of that.

9           So I think, again, everybody needs to be  
10          involved, not on one big panel, but on multiple  
11          panels. And if we want to look at where people  
12          have conflicts so that you'd then be assigned to  
13          an overlapping two sites, that might be the way  
14          we could break it up, and people would then  
15          become expert in those particular two comparison  
16          sites.

17                 **DR. ZIEMER:** Thank you.

18                 Wanda.

19                 **MS. MUNN:** Yes, I'd like to agree especially  
20          with one thing that Henry said. With respect to  
21          data that we're looking at, I was really bothered  
22          during Mark's presentation by the word "accuracy"  
23          of data. I can see no way that anyone can look  
24          at 50-year-old data and determine whether it is  
25          accurate. We might be able to have a shot at

1 making some assessment of the quality of the  
2 data. But accurate? I don't know how you'd do  
3 that. I just don't know how to do that. And if  
4 we start off saying one of the things we're going  
5 to do is try to identify the accuracy of the  
6 data, it seems to me we're setting ourselves up  
7 for an impossible task. The quality, the  
8 quantity, the source can be determined. But how  
9 do we say, even if the data is complete, that it  
10 was accurate from 50 years ago?

11 **DR. ZIEMER:** Let me insert at this point, and  
12 I think this is an issue that the NIOSH people  
13 are trying to address as they look at the various  
14 sites, because with each system there is  
15 calibration information that in fact allows you  
16 to establish some level of accuracy with some  
17 degree of error or uncertainty. So in principle,  
18 you can do it if they have enough information on  
19 the calibration processes.

20 **MS. MUNN:** Degree of confidence I can  
21 understand, but I'm concerned about our obsession  
22 with accuracy.

23 I certainly agree with everything that's been  
24 said here relative to the desirability of small  
25 groups as opposed to large groups.

1 I'm concerned with the comment about  
2 stratification. I understand and agree that some  
3 significant amount of it is necessary, but that's  
4 one of those areas where you can get yourself  
5 into a real quagmire trying to get too specific  
6 in identifying too many different strata.

7 And the number, the percentage of cases, is  
8 one of those things that perhaps we should look  
9 at a little more carefully. I don't know that we  
10 achieve an awful lot by identifying a specific  
11 percentage. Perhaps there might be some other  
12 type randomness that would serve as well.

13 This is a question that I don't know the  
14 answer to. I recognize the real problem vis-a-  
15 vis identifying well-qualified people to do this.  
16 Is there some possibility that one of the things  
17 which might also add one more degree of  
18 objectivity is the consideration of individuals  
19 from outside the United States who are qualified  
20 to do this type of thing? I can think there are  
21 maybe individuals in Britain, for example, who  
22 would have the same general broad experience that  
23 we would want, also maybe France. Don't know  
24 whether that's even possible for us to do, but  
25 it's worth thinking about.

1           **DR. ZIEMER:** Thank you.

2           Henry, again.

3           **DR. ANDERSON:** Yeah, on the two and a half  
4 percent, I think, one, we have to ask ourselves,  
5 we could do a power calculation on our likelihood  
6 to be able to detect the degree of problem that  
7 if we're just checking to see were errors made,  
8 we can look at what NIOSH is going to be doing  
9 for their QA/QC activity and see whether we need  
10 to do something similar.

11           The other thing we may want to think about if  
12 we do a relatively small percentage is do we want  
13 to have an appeal process where individuals could  
14 request to have their records reviewed, and we  
15 then have a process for selecting a certain  
16 percentage of those so that it -- while that's  
17 not part of a random or a stratified sample,  
18 there may be issues that in a random process  
19 wouldn't be identified when an individual may  
20 say, gee, you know, they totally ignored this,  
21 and it wouldn't get into a -- the review process.  
22 So we may want to think in terms of having a  
23 capacity for individuals to say, gee, I'd like to  
24 have this reviewed by a panel. We'd have to put  
25 some restraints on how many of those we could

1 handle, but that might be another way to allow  
2 individuals who will be the ones that may be  
3 concerned about it to have their records  
4 reviewed, and then you would have some process  
5 like that.

6 **DR. ZIEMER:** Maybe we can ask the staff at  
7 this point if there is a type of appeal process  
8 already for those, particularly in the middle of  
9 the scale, I think. But I'm not sure if you're  
10 talking about that, or the Board acts as appeal -  
11 -

12 **DR. ANDERSON:** No, no, no, not -- only as to  
13 what the panel will be doing as the reviewer of  
14 the records and the other activities. If we set  
15 as our goal here what is this review going to  
16 accomplish, and if the review is to determine the  
17 completeness and the systematized or systematic  
18 approach that's been used to be sure that things  
19 are not missing or whatever, individuals who  
20 believe their data is more missing than somebody  
21 else's, we might have that as opposed to the  
22 decision process that was made.

23 **DR. ZIEMER:** Perhaps this parallels the point  
24 that Tony made originally, and let me -- and I'll  
25 ask Tony this question, because you were sort of

1 saying bottom line, what happens if the panel  
2 says a mistake was made or that the database is  
3 inadequate, or there's some flaw in the process  
4 of the dose reconstruction? And I believe you  
5 were suggesting that perhaps as part of this  
6 process we think about how do you handle that.  
7 What happens when that occurs?

8 And that might be something, Mark, that the  
9 group should also address. What happens if in  
10 fact there is a concern raised? Does it bounce  
11 back to staff to redo something, or just what  
12 happens? I don't think we have to answer that  
13 right now, but certainly that's an important -

14 Was that the nature, Mark -- Tony, of what  
15 you were asking?

16 **DR. ANDRADE:** That was precisely what I was  
17 asking about. I know that it's already law  
18 insofar as what the appeals process will be for  
19 those people who would like to have their cases  
20 reviewed. However, as an advisory body -- again,  
21 not an expert body -- if we do find something  
22 lacking in terms of the quality of reviews or a  
23 review, the open question is what do we do? How  
24 do we feed back into the process? And I think  
25 that's really the route that we should take.

1           **DR. ZIEMER:** Additional input?

2           **DR. NETON:** This is Jim Neton. I think  
3 that's been addressed, in the sense that if the  
4 case has been through final adjudication and then  
5 the person has appealed, and essentially he had  
6 lost or been turned down at that point and the  
7 Board has reviewed the case, I think what would  
8 happen is the recommendation would be referred  
9 back to NIOSH. We would evaluate that, and then  
10 with our capability to turn back to the  
11 Department of Labor and say reopen that case, we  
12 feel there's new information that's come to light  
13 that would warrant reopening that case at that  
14 time. So I think that the way the mechanism  
15 works is it would all come back through NIOSH to  
16 be able to -- we would recommend the case be  
17 reopened at that point. That has been addressed.

18           **DR. ZIEMER:** Jim, is that -- do we know for  
19 certain that that process is already well  
20 codified in the --

21           **DR. NETON:** Well, I think Ted could probably  
22 answer this better than me, but I think the last  
23 rev allowed NIOSH to --

24           **DR. ZIEMER:** For a variety of --

25           **DR. NETON:** For a variety of reasons, one of

1 which would be the Board's review. That's  
2 essentially, I think, the only mechanism that's  
3 open to reopen a case that's been through final  
4 adjudication.

5 Is that correct, Ted?

6 **MR. KATZ:** Yeah, it's -- Ted Katz. The  
7 specifics are not in the reg. They're in the  
8 implementation. But it's broad enough as it's  
9 written in the reg to accommodate that perfectly.

10 And just the other thing I would just mention  
11 is obviously, for dose reconstructions that are  
12 recently completed, there may be an opportunity  
13 to -- if those go before the Board for people who  
14 are unhappy with those before the claim is  
15 finally adjudicated, then that sort of shortcuts  
16 the process in terms of how do you remedy a  
17 problem if you find one.

18 **DR. ZIEMER:** Thank you.

19 Roy.

20 **DR. DEHART:** I would like to thank you all  
21 for joining us on the frustration of the amount  
22 of material that we're going to have to consider  
23 here.

24 I find it difficult to perceive in my own  
25 mind just what we're talking about. I haven't

1           seen a case, so I have no idea what the data is,  
2           what the datasets consist of, what the interview  
3           information happens to be, whether or not there's  
4           classified data in there that would require Q  
5           clearance of those of us who are participating in  
6           the reviews. There is a lot of information that  
7           -- I would like to ask NIOSH if they could put  
8           together for us some dummy files so that we can  
9           begin to see what the mass of information is  
10          going to be that we're going to be responsible  
11          for reviewing.

12                 **DR. ZIEMER:** I think I heard a sort of a nod  
13                 or a yea?

14                 **MR. ELLIOTT:** Larry Elliott. Yes, we can  
15                 certainly do that. We can prepare some -- I  
16                 think what you should start with is the de-  
17                 identified administrative record for the file.  
18                 That contains everything that was used to support  
19                 the file -- the case.

20                 **DR. NETON:** That may be very difficult to  
21                 accomplish. These cases have 4- or 500 pages of  
22                 information, in many cases, that we would have to  
23                 go and redact virtually every single page, if we  
24                 could do that.

25                 **MR. ELLIOTT:** But I think we will do that.

1           **DR. ZIEMER:** I think Roy is requesting -- we  
2 need to get a feel for what we're talking about.  
3 It's not a simple matter of having a few pages  
4 and a quick calculation, saying everything looks  
5 good.

6           **DR. NETON:** Well, I just wonder if the Board  
7 couldn't -- the small working group in  
8 particular, just looking at an actual case rather  
9 than redacting one. It would be simpler to just  
10 turn over a case or two to the working group,  
11 rather than to start redacting thousands of pages  
12 of information. Just a practical suggestion.

13           **DR. ZIEMER:** That might be a way for -- the  
14 working group could then develop a feel and  
15 report back to the whole, full Board on the  
16 magnitude of the effort.

17           **MR. ELLIOTT:** We'll provide the Board  
18 something, the administrative record, and we'll  
19 take into consideration what needs to happen to  
20 provide that to you. It'll be done.

21           **DR. ZIEMER:** Wanda.

22           **MS. MUNN:** Or alternatively, it may be  
23 simpler and less work in the long run to just  
24 simply have our working group go visit NIOSH and  
25 talk to the staff, take a look at some of the

1 files. That might be the simplest way to get a  
2 feel for what has to be done.

3 **DR. ZIEMER:** Again, I don't know that we have  
4 to decide that at this moment.

5 But maybe, Mark, as your group addresses this  
6 later today and talk with the staff, and you can  
7 develop a strategy on how that might best be  
8 accomplished. Is it a visit to Cincinnati, or to  
9 a site, or what --

10 **MR. ELLIOTT:** It would have to be in  
11 Cincinnati, but we could accommodate that kind of  
12 a visit, too. Maybe it's a combination of both  
13 those things that needs to happen.

14 **DR. ZIEMER:** Mark, let me ask if you have  
15 additional questions for the full group here now  
16 before -- do you have enough sort of feedback and  
17 ideas and stimulating comments that will be  
18 helpful to your group as you proceed?

19 **MR. GRIFFON:** Yeah, I hope so. And Roy  
20 pointed out well that that was part of our  
21 frustration in this, was sort of talking in the -  
22 - without being able to see case files and know  
23 the process, and know how many cases from what  
24 areas, we were kind of -- so I think it's all --  
25 a lot of the points that came up, although there

1 were certainly some new ones that we appreciate,  
2 a lot of them we have jumbled around within our  
3 conference calls, and where we couldn't quite  
4 come to some conclusions. So that was very  
5 helpful.

6 I should point out also that we also noted  
7 the -- I think most of us agreed that the nine-  
8 member panel wasn't a construct that we were  
9 really looking at. We were looking at less  
10 members. And what we did want, we did talk of  
11 one to three Board members. And we threw around  
12 the notion of rotating Board members, too, so --

13 **DR. ZIEMER:** I'd like to get a, in fact, a  
14 kind of a straw poll feel for how the Board  
15 reacts to -- I guess it was, Henry, your  
16 suggestion that there be perhaps multiple groups,  
17 allowing each of the Board members to participate  
18 in some way in this. How many like that idea and  
19 would be willing to be involved in such a group?

20 (Show of hands)

21 **DR. ZIEMER:** We're not holding you to this. I  
22 just want to get a feel for whether -- is Henry  
23 the only one that likes this idea?

24 (Laughter)

25 **DR. ANDERSON:** You won't get volunteers

1 otherwise.

2 **DR. ZIEMER:** Mark.

3 **MR. GRIFFON:** I'm sorry, one point of  
4 clarification on that. Henry, in your model are  
5 you talking about multiple panels?

6 **DR. ANDERSON:** I was just assuming that we  
7 would kind of spread the work around. Now  
8 whether it could be rotating people but a fixed  
9 number of experts, that, I think, has some  
10 benefit versus multiple panels. I think it  
11 depends on how long it takes to do a case review  
12 if we're going to do this. That's why I would  
13 ask the VA or whatever, if we're going to have 20  
14 files to review and it takes several hours per or  
15 a day per, the group is going to get bogged down  
16 unless you have multiple groups. But rotating  
17 certainly would be a way to do it.

18 **DR. ZIEMER:** And if you do it that way,  
19 sometimes what you do is you give a common file  
20 to several of the groups to sort of cross-  
21 calibrate them, to see if they --

22 **DR. ANDERSON:** Right, yeah. You'd have to  
23 kind of set up a study design, as it were.

24 **DR. ZIEMER:** Right. In other words, is the  
25 outcome on the panel or did you reach the same

1 conclusion if you have a different set of  
2 reviewers?

3 **DR. ANDERSON:** Right.

4 **DR. ZIEMER:** Bob.

5 **MR. PRESLEY:** I agree. I agree with Roy and  
6 with Henry, because the way our schedules are at  
7 times, a lot of people are not going to be able  
8 to be there, or are going to have a conflict of  
9 interest. And if you had maybe two panels that  
10 could swap back and forth with your experts, I  
11 believe that would be a lot better.

12 **DR. ZIEMER:** You have additional questions  
13 you want --

14 **MR. GRIFFON:** I think we have something to go  
15 on tonight, so thanks for the input.

16 **DR. ZIEMER:** Larry.

17 **MR. ELLIOTT:** One of the ideas that I heard  
18 expressed -- I'm not sure as to who expressed it  
19 -- but was to hear from the VA about their  
20 experience and their protocol. And I'd ask you  
21 to kind of think through that a little bit. Do  
22 you want that as a presentation to the Board? Do  
23 you want to have just the working group interact  
24 with the VA and report back to the Board? How  
25 would you -- think about how you would like to

1 effect that so that we could put it into play for  
2 you.

3 **DR. ZIEMER:** Well, let's get it -- let's find  
4 out right here.

5 **MR. GRIFFON:** Well, just a question on that,  
6 because I did some follow-up phone calls. And  
7 the NAS -- I never did get a hold of John Till,  
8 as I mentioned -- but the NAS sort of stopped --  
9 they weren't very specific with protocols. They  
10 said they couldn't get specific with me with  
11 protocols. I don't -- is that something they can  
12 share now? Do people know? Or are they still  
13 working on their protocols, and -- because the  
14 most I got was on a web site from NAS, where it  
15 described the scope of work. And we did look at  
16 that, and those last slides sort of overlap with  
17 some of that. But as far as specific protocols,  
18 they said they couldn't share at this point.

19 **DR. NETON:** I think I may be able to address  
20 that a little bit. The NAS review is really a  
21 one-shot review that was commissioned as a result  
22 of (inaudible) investigations, so it has a  
23 somewhat different focus than what you guys are  
24 all trying to set up, which is an ongoing review  
25 process. So I suspect that they don't want to

1 review -- to release their protocols because it's  
2 an ongoing study that's not been completed. So I  
3 don't think that they're probably willing to  
4 share at that time, but once the study's released  
5 I think they can share with all.

6 **DR. ZIEMER:** So it's a different --

7 **DR. NETON:** It's a different focus than what  
8 we're trying, or what you all are trying to do  
9 here. So it's relevant to look at what they're  
10 looking at, to examine what they're looking at.  
11 But their process and protocols, I think, are  
12 somewhat different. It's reviewing 20 years  
13 worth of work, or something like that.

14 **DR. ZIEMER:** It appears, then, that that  
15 wouldn't be so useful. Is that correct? Is it  
16 the VA, or the -- the VA staff versus the NAS  
17 review panel.

18 **MR. ELLIOTT:** Right. I think what Jim's  
19 characterizing is the NAS review of the VA --

20 **DR. ZIEMER:** Well, then that may not be so  
21 helpful.

22 **MR. ELLIOTT:** If you want to hear -- yeah,  
23 right. If you want to hear about the VA model  
24 and their approach in reviewing dose  
25 reconstructions, that's what I -- or any other

1 models that you might identify for us, and how we  
2 might bring them to your awareness.

3 **MR. PRESLEY:** Would there be a possibility,  
4 if we did go to Cincinnati to review cases, to  
5 have the VA at that point talk to us, kill two  
6 birds with one stone?

7 **MR. ELLIOTT:** Well, again, that's something  
8 to be considered as an approach, yes. But again,  
9 I would take it back to do you want the whole  
10 Board engaged, or do you just want the working  
11 group engaged? I think it could go different  
12 ways. And so all I'm asking is to think through  
13 this, and then place something in front of me  
14 that I can effect for you.

15 **DR. ZIEMER:** Let's not -- let's hold that  
16 till tomorrow.

17 Maybe -- Mark, maybe your group can address  
18 that question as well.

19 Certainly we can't -- I shouldn't put it that  
20 way. We probably don't want the whole Advisory  
21 Board to be going to review the sample cases  
22 because this becomes an official meeting at that  
23 point, and this is something, because of the  
24 confidentiality of the files, we can't really do  
25 in public. So that's got to be the smaller

1 group. If the whole Board wishes to hear from  
2 the VA, then we can schedule that as part of a  
3 regular meeting.

4 **DR. NETON:** I'd just like to offer one point,  
5 a minor correction. It really is the Defense  
6 Threat Reduction Agency that is responsible for  
7 conducting the dose reconstructions that is  
8 turned over to the Veterans Affairs, so it would  
9 be -- or their contractor.

10 **DR. ZIEMER:** For the record, that's what we  
11 need, then.

12 Okay, I think we're at a point where we're  
13 ready to take our morning break, so let's do that  
14 at this point. We'll reconvene at 10:45.

15 (Whereupon, a break was taken at 10:20 a.m.)

16 - - -

17 **DR. ZIEMER:** Okay, we're back in session.

18 The next item on our agenda is Special  
19 Exposure Cohort petitioning. You recall that the  
20 *Federal Register* notice 42 CFR part 83 appeared  
21 just this past week, June 25th to be exact, the  
22 proposed rule. That rule is open for public  
23 comment actually till August 25th or -6th, a 60-  
24 day period. Ted Katz is going to lead us through  
25 the document, then we'll have an opportunity to

1 discuss.

2 So Ted, if you would, please.

3 **MR. KATZ:** Thank you.

4 Okay, so I'm going to give an overview, a  
5 little bit of background. I realize the Board --  
6 for the Board, this background's a bit redundant  
7 at this point, but there may be people in the  
8 audience who don't have your experience already  
9 with this. And then I'm going to talk about the  
10 rule. I'm not going to run through the rule in a  
11 section-by-section forum, which I think would  
12 drive you crazy at this point. And I realize the  
13 Board may want to later, actually, as they've  
14 done with the previous two rules, review the rule  
15 in that process. But I'm going to try to get  
16 some essential points up before you. So some  
17 background here about the cohort.

18 Congress, in enacting, and the President, in  
19 enacting EEOICPA, established an initial cohort  
20 from four facilities, three gaseous diffusion  
21 plants and a nuclear test site in Amchitka,  
22 Alaska. And the Board has had a presentation  
23 about that process of establishing the initial  
24 cohort from Dr. David Michaels, who explained a  
25 little bit about the background and how that

1 worked for Congress to make the decisions they  
2 made. But in addition, it was realized that the  
3 cohort may need expanding, and let me explain  
4 this.

5 The cohort, for people who are in the Special  
6 Exposure Cohort, they are not required to have  
7 their doses reconstructed individually and to  
8 have a probability of causation determination to  
9 determine whether it's at least as likely as not  
10 that their radiation dose has caused their  
11 cancer. In their cases there is a presumptive  
12 finding that because they were employed at the  
13 sites and meet certain minimal criteria that are  
14 specified in EEOICPA and addressed in the DOL  
15 regulations, they will be compensated if they  
16 incur one of 22 specified cancers.

17 And the one other point I should just make  
18 about this is they are compensated under the  
19 cohort provisions only for these 22 specified  
20 cancers. And as we discussed with the dose  
21 reconstruction rule and probability of causation  
22 rule in the past, some of these individuals, if  
23 they don't have one of these 22 specified  
24 cancers, they can seek a dose reconstruction from  
25 NIOSH, and we will attempt to do a dose

1 reconstruction. This will be an important point  
2 as we go forward in talking about this rule.

3 Adding to the cohort, I think I've covered  
4 this basically. Congress assigned this  
5 responsibility to the President, who delegated  
6 the responsibility for adding to the cohort to  
7 the Secretary of Health and Human Services. So  
8 that's where the buck stops. That's the person  
9 who makes the decision ultimately whether to add  
10 or to deny adding a class of employees to the  
11 cohort.

12 Now Congress did give some broad statutory  
13 requirements to guide the President and Secretary  
14 of HHS as to how it was to go about this process  
15 of considering and adding classes to the cohort.  
16 Two criteria were identified: One, that it's not  
17 feasible to estimate radiation doses with  
18 sufficient accuracy; and the second criteria,  
19 reasonable likelihood that these radiation doses  
20 endangered the health of the class.

21 And then there were also some specifications  
22 with respect to the process. One, that HHS was  
23 to consider petitions by classes of employees to  
24 be added to the Special Exposure Cohort. This is  
25 how we come to consider a class. And secondly,

1 that after giving consideration to a petition as  
2 appropriate, we would get the advice of the Board  
3 on whether or not to add that class. And there's  
4 more -- it's worded more specifically in the Act,  
5 but this is the meaning.

6 Congress also allowed itself, as it was said  
7 to me from a Congressional staffer, a sort of  
8 escape hatch, a Congressional review period. So  
9 for affirmative decisions, if the Secretary of  
10 HHS decides that a class should be added to the  
11 Special Exposure Cohort, that decision and its  
12 basis go to Congress, and Congress has 180 days  
13 to consider that decision. And I'll be more  
14 specific in how we interpret that.

15 Now I've separated the presentation into two  
16 pieces, really. The front end, I want to talk  
17 about sort of the substantive work of evaluating  
18 whether a class should be added or not to the  
19 cohort. And then on the second half of this  
20 presentation I'll talk about then the process for  
21 doing those evaluations, for considering  
22 petitions and doing those evaluations.

23 So key technical issues, these are what we  
24 just identified in the Act. They come from the  
25 Act. We need to be able to determine for a class

1 when it's not feasible to estimate radiation  
2 doses with sufficient accuracy, and when is there  
3 a reasonable likelihood that the radiation  
4 endangered the health of members of the class.  
5 What I'm going to do now is just sort of drill  
6 down into these concepts as to how HHS has  
7 interpreted this.

8           The sufficient accuracy first. There is,  
9 first of all, there was a discussion earlier  
10 about the difference between -- well, about  
11 accuracy. And I recognize there's a difference  
12 between accuracy and precision from a  
13 statistician's or a scientist's point of view,  
14 and you discussed some of the problems with  
15 dealing with the issue of accuracy. But I think  
16 in this case really the issue is precision, and  
17 there is no gold standard for precision. It's an  
18 entirely utilitarian concept. It depends what  
19 you're doing how precise you need to be.

20           And our practical answer to this was we need  
21 to be able to estimate doses to enable the  
22 sufficient -- to enable fair adjudication of  
23 claims. This is our answer. And it sounds on  
24 the front of it, I think, a little bit circular.  
25 If we can do a dose reconstruction, what we're

1 saying, then they will be sufficiently accurate.  
2 And the reason we say that is because the way  
3 we've designed the dose reconstruction process is  
4 to first and foremost ensure the fair  
5 adjudication of claims. And what that means with  
6 respect to precision is that we'll either be able  
7 to estimate the doses with uncertainty properly,  
8 in which case we're all right. Or -- I'm sorry,  
9 I'm losing my place here. Let me move to the  
10 next three sub-questions here.

11 Can we reasonably estimate -- this is what  
12 we've said before -- can we estimate the doses?  
13 It means can we do, give you essential estimate  
14 and a dose distribution around that? If not, can  
15 we reasonably estimate the upper limit of the  
16 dose? These next two provisions are if so, and  
17 if so is it below or above a compensable level?  
18 This is what we've talked about before. In some  
19 cases we may not be able to produce a proper dose  
20 estimate with uncertainty limits, but we can cap  
21 the dose estimate. We can give a worst case of  
22 what that dose might be. With very low doses,  
23 that would be sufficient to produce a dose  
24 reconstruction. We would be giving them, in  
25 effect, then a worst-case dose reconstruction

1           versus a dose estimate with uncertainty  
2           parameters. But nonetheless, fairness would be  
3           assured here, we believe.

4           When is dose reconstruction infeasible? And  
5           this was discussed again with the dose  
6           reconstruction rule, I think. Substantially,  
7           again, it's a case-by-case determination only,  
8           and there are limitations just to really  
9           explicate that that could prevent a dose  
10          reconstruction, which we talked about in the dose  
11          reconstruction rule.

12          Really these three parameters all, when we  
13          fall short on all three, we have a problem doing  
14          dose reconstruction. And that's lacking personal  
15          or area monitoring records for radiation exposure  
16          -- and here, just to clarify, I'm talking about  
17          not the fact that there are some personal  
18          exposure monitoring or area monitoring, but the  
19          issue is where are we lacking such records. And  
20          secondly, where we don't have sufficient  
21          information on the radiation source to estimate  
22          doses. And this goes hand-in-hand with the  
23          third, where we don't know enough about the work  
24          processes involving the radiation sources, or  
25          where they could result in a hazardous dose. And

1 here I'm talking about a compensable dose. And  
2 in effect if we can't get a handle on this, how  
3 high the dose might be, and we can't put  
4 uncertainty parameters on it, we can't do a dose  
5 reconstruction.

6 I should mention, we've had a presentation  
7 for a small stakeholder group about this rule,  
8 and one of the issues that was raised in that  
9 meeting was this whole question of feasibility  
10 again. When is it feasible for NIOSH to do a  
11 dose reconstruction? And our response in that  
12 discussion with the stakeholders is really that  
13 feasibility is a knotty issue when it comes to  
14 regulations, when it comes to getting a specific  
15 standard in place. And it's a problem in other  
16 areas of public policy as well, and people  
17 probably in this group understand how it's a  
18 problem when it comes to OSHA law. Feasibility  
19 is a big issue there. It gets determined on a  
20 case-by-case basis. There's really no better --  
21 it's like trying to define joy. It doesn't  
22 accommodate itself well to a regulatory process.

23 But it is something to point out that we'll  
24 be addressing on a case-by-case basis, and an  
25 issue which then will be coming before the Board

1 under those circumstances. The Board will be  
2 reviewing dose reconstructions and seeing those  
3 instances where we're not. If you're stratifying  
4 across all sort of possibilities, you'll be  
5 looking at instances where we couldn't do a dose  
6 reconstruction. And when we are considering  
7 classes, of course, every time we consider a  
8 class for a Special Exposure Cohort you'll be  
9 looking at the logic behind our finding that we  
10 couldn't do a dose reconstruction. So there is a  
11 public process for reviewing that.

12 The next term I'd like to define, "endangered  
13 the health." That's very broad. HHS interpreted  
14 this to mean potentially caused a specified  
15 cancer. The reason we did that is because there  
16 is no benefit to being part of the Special  
17 Exposure Cohort for any other end point, health  
18 end point. Only if you have a specified cancer  
19 can you be compensated.

20 And then "reasonable likelihood" is another  
21 term that has no standard definition, but we had  
22 a lot to work with, we thought, in terms of using  
23 this definition or defining this further. We  
24 have NIOSH-IREP, which is designed to address the  
25 whole issue of likelihood under EEOICPA. And we

1 thought to the extent we can be consistent we  
2 should be consistent between claimant groups, so  
3 using NIOSH-IREP was the preferred approach. And  
4 again, similarly, the 99th percentile credibility  
5 limit that's being applied in using NIOSH-IREP  
6 for people who can have dose reconstructions, we  
7 wanted to apply it here. The big difference is -  
8 - comes in the specifics of NIOSH-IREP, the  
9 variables that you use. Because as you all  
10 understand, in this case we're not talking about  
11 an individual, we're talking about a class. And  
12 that raises obviously a whole different situation  
13 with respect to the particulars that you put in  
14 NIOSH-IREP.

15 And these are the variables where this is  
16 relevant. Cancer type/site; radiation type,  
17 doses and dose parameters; radiation source I  
18 should add to that, too; cancer latency; age at  
19 exposure and cancer diagnosis; other demographic  
20 variables; and smoking history, which is relevant  
21 only for lung cancer. For all these variables  
22 what the rule says is in effect what we'll do for  
23 a class, since we're not talking about an  
24 individual, is choose these parameters to give  
25 the benefit of the doubt to that class because in

1 many cases, in most cases, perhaps, none of these  
2 parameters will be known. But the rule also says  
3 that where we do have a handle on the profile of  
4 the class, we'll be certainly attending to that  
5 profile in making these assignments. We're not  
6 going to make assignments that completely sort of  
7 disregard the actual facts of the class.

8 Let me -- let me -- wait, I can't go back,  
9 can I? There's no going back. Maybe I'll leave  
10 this up here and talk about it instead of trying  
11 to change it, but let me -- I'm going to talk  
12 about two of those variables. If we need to go  
13 back and you want to look at the other variables,  
14 we can. The two variables I'm going to talk  
15 about is selecting the cancer type and latency,  
16 which are two clearly very important variables in  
17 what probability of causation you determine. And  
18 what the rule says is that we will -- and it  
19 depends on the radiation exposure -- we will  
20 choose the most radiogenic cancer, which means  
21 the cancer that's caused by the lowest dose, in  
22 effect, at the 50 percent level. We will use  
23 that as our parameter in NIOSH-IREP.

24 And there's sort of a different situation you  
25 have when you're dealing with radiation exposures

1 that are from internal dose versus external dose.  
2 If there's external dose, then leukemia is going  
3 to be the most radiogenic, in most cases, most  
4 radiogenic cancer. And the problem addressed in  
5 the rule in that situation is that leukemia can  
6 have, depending on the specifics, a phenomenally  
7 low dose threshold, one and a half rem, perhaps.  
8 And in that case you're basically saying  
9 everybody qualifies. At practically no radiation  
10 dose you would add the class to the cohort.

11 And the problem with that is that there's a  
12 balance to be struck between individuals who may  
13 come forward in the class and the class as a  
14 whole. And we're having to make a judgment about  
15 what threshold is appropriate for the class as a  
16 whole. If it's an extremely rare cancer and you  
17 have 50 people who are part of that class, the  
18 chances are you'll have no leukemia cases in that  
19 class, or 100 or 200. And the problem is should  
20 that be then your measure if in all likelihood  
21 those people will be presenting solid tumors for  
22 which probability of causation is substantially  
23 higher? So we propose splitting the difference  
24 in these cases, splitting the difference, taking  
25 an average between what applies for leukemia,

1           what radiation dose level would be the threshold,  
2           and the radiation dose level that would be the  
3           threshold for solid tissue tumors.

4           And then it gets more complicated, as you  
5           see, because latency is a big issue, and latency  
6           works in opposite directions with respect to  
7           leukemia and solid tissue cancers. In other  
8           words, low latency -- if a cancer occurs very  
9           soon, with leukemia it's more likely that the  
10          leukemia's caused by radiation exposure; whereas  
11          with solid tissue tumor cancers, generally  
12          speaking, a much longer latency increases the  
13          probability that that cancer was caused by  
14          radiation exposure.

15          So this is an issue for the Board to dig into  
16          if it supports the concept here of doing this,  
17          splitting the difference, is how do we go about  
18          addressing latency versus the cancer type? As  
19          you can see here -- and one thought that we would  
20          put forward is that we would be claimant-friendly  
21          to the extent that we lack information on the  
22          class in both directions, so we wouldn't be  
23          choosing the same latency for leukemia as we  
24          would for the solid tissue, solid tumor cancer.  
25          So we'd use, in other words, a low latency for

1 leukemia, a long latency for the solid tissue  
2 cancer, and be averaging those doses. But this  
3 is something that certainly deserves discussion  
4 by the Board.

5 Now where we have clear specifics on the  
6 class -- it was a very small class, we know all  
7 the individuals, we know when they incurred  
8 cancer and so on -- then we would abide by the  
9 facts that describe the class.

10 Now I'm going to move from then substantive  
11 issues to the process we'll go through, what  
12 we're proposing to go through for evaluating  
13 claims. And these are our goals: To establish  
14 an evaluation process that is public, thorough,  
15 and fair -- underline thorough; achieve timely  
16 consideration of petitions -- you'll see why this  
17 is an important issue; and invite maximum  
18 petitioner involvement -- just as under the dose  
19 reconstruction, we try to involve claimants to  
20 the maximum extent possible.

21 Who can petition? The Act requires that  
22 classes of employees petition, so we've  
23 interpreted this as broadly as we saw appropriate  
24 to mean covered employees and/or their survivors,  
25 as well as unions representing or having

1 represented employees, since in some cases it may  
2 be past tense for the unions. But they would all  
3 be qualified to petition.

4 And the basis for the petition: There really  
5 are sort of two tracks, in a sense, for  
6 petitioning. And the one is one that this Board  
7 understands, I think, already. It's the case  
8 where we've already attempted to do a dose  
9 reconstruction and were unsuccessful, found there  
10 are not sufficient records to do a dose  
11 reconstruction. And in that situation, in effect  
12 the petitioner would have to do no more. The  
13 petitioner would bring that to us, that finding  
14 to us, and at that point we would go on with  
15 defining the class initially and evaluating the  
16 two criteria that we just discussed as to -- and  
17 the first criteria is, of course, met for the  
18 individual already, and the question is is how  
19 many other individuals are in that petitioner's  
20 shoes in terms of it not being feasible to do a  
21 dose reconstruction?

22 Now if there hasn't been a dose  
23 reconstruction attempted for anyone in the class,  
24 then we require substantial grounds on behalf of  
25 the petitioner for believing that the class may

1 have met the requirements of being added to the  
2 cohort. And let me just say we're not requiring  
3 for them to do our evaluation for us, which I'll  
4 get into, our evaluation of those two factors,  
5 but simply to show that they've made a  
6 substantial effort to determine whether or not --  
7 within their means to determine whether or not  
8 dose reconstruction is an unlikely possibility  
9 for them.

10 And if you want me to run through those,  
11 they're written out in the rule, but in effect  
12 we're asking them to define who is the class  
13 they're talking about initially. And that's an  
14 initial definition, which will be addressed and  
15 possibly changed as we go through the evaluation  
16 process, and I'll get back to that later. We're  
17 also asking them to determine what records are  
18 available, if there are records available  
19 concerning exposures they believe there are  
20 uncovered by DOE records, and for us to show some  
21 reason to believe that they were exposed to  
22 radiation. So it's fairly minimal, I think, and  
23 we will be providing them with a petition form  
24 that draws out as much information that could be  
25 useful to us as possible, and we'll be working

1 with them then, as they may have problems in  
2 responding to that form, to help them complete  
3 that form.

4 The next step is that there'll be an  
5 evaluation made by HHS as to whether or not they  
6 meet the basic criteria for having their petition  
7 evaluated, and they'll be informed of that. The  
8 next point, if they don't, the question is is  
9 what recourse do they have. And all of these  
10 petitions that HHS is considering evaluating will  
11 come before this Board with -- and where we have  
12 made a recommendation, HHS has made a  
13 recommendation that there's not a basis for  
14 considering this petition, the Board will have a  
15 chance to review that recommended finding and  
16 dispute it, dig into it more, whatever. But HHS  
17 will not make final decisions until this Board  
18 has had a chance to consider those decisions.

19 Now what happens once we've selected a  
20 petition to evaluate? NIOSH will evaluate the  
21 petition and report the results to the  
22 petitioners. We will be evaluating the two  
23 factors that I discussed, the substantive key  
24 technical issues. So the burden will be on NIOSH  
25 to go to DOE, to go to AWEs, to go to the other

1 resources that are available to it, including the  
2 petitioners, of course, to dig up as much as  
3 possible information to make these decisions.

4 It will then report to the Board. It will  
5 report, providing its initial definition of the  
6 class based on that evaluation. The class may be  
7 different at that point, having evaluated it,  
8 than the class was proposed. For example, a  
9 class may have been proposed that in fact  
10 represents several classes with different  
11 circumstances, different exposure experiences,  
12 different record availability, and so on. If  
13 that's the case, at that point NIOSH will be  
14 recommending in fact there are two classes here  
15 for which decisions need to be made, and those  
16 will receive separate decisions. On the other  
17 hand, NIOSH could receive several petitions that  
18 in fact should all be bundled into one because  
19 they really represent the same class of workers.

20 In any event, we'll produce this report that  
21 will define the class or classes, and it will  
22 address the substantive issues that I've  
23 discussed before and provide the basis for a  
24 recommendation. The petitioner at that point --  
25 this will be presented to the Board, and the

1 petitioner will have an opportunity to come  
2 before the Board and make a case if the  
3 petitioner disagrees with the NIOSH evaluation,  
4 and the Board will have an opportunity to advise  
5 NIOSH on whether it needs to do further work in  
6 evaluating the petition. After this process with  
7 the Board, HHS will recommend a decision and the  
8 basis to the petitioners, who may contest that.  
9 That's a contestable decision, and there will be  
10 an administrative review when there are contests.  
11 After those contests they have 30 days to bring  
12 contests in those cases.

13 After that's resolved, HHS will publish and  
14 report final decisions. Now that's sort of a  
15 different -- a staggered approach here. Denials  
16 of petitions we will publish in the *Federal*  
17 *Register* and report immediately. We will report  
18 all decisions immediately, but if HHS has made an  
19 affirmative decision we actually will report our  
20 decision and its basis to Congress first, as I  
21 mentioned earlier, and Congress has 180 days to  
22 act on that decision. And HHS interprets that  
23 role of Congress as to either expedite the  
24 decision -- Congress would have to pass a law to  
25 do anything, we believe, but to say that the

1 class, instead of waiting 180 days, will be  
2 effective at whatever point, immediately. Or  
3 vice versa, Congress could decide that it's going  
4 to in effect deny the petition after HHS has  
5 affirmed it, that it will not become effective,  
6 reject it.

7 And this is just to make clear the point I  
8 made earlier, that whatever the class definition  
9 is going into this process, at the end of the  
10 evaluation process the class definition may  
11 differ, and you may have more than one class  
12 you're actually talking about, or less than  
13 several classes you're talking about in the  
14 output here.

15 And then finally, there's a provision in the  
16 rule to cancel a cohort addition. And this  
17 relates to the sort of basic premise there isn't  
18 sufficient information to do dose  
19 reconstructions. There've been some experiences  
20 in the history of DOE where information comes to  
21 light, no one knew, no one was aware of, comes to  
22 light, it provides sufficient information to  
23 estimate doses. So in that case, if we received  
24 information and were able to, at that point HHS  
25 would cancel, after a due process of evaluating

1 that new information, which again would come  
2 before the Board and so on in the same sort of  
3 process that a petition comes before the Board,  
4 but HHS could decide ultimately to cancel a class  
5 at that point.

6 And that, I believe, concludes my slide  
7 presentation.

8 **DR. ZIEMER:** Okay, thank you, Ted.

9 Let's open the floor for discussion. Now let  
10 me pose a question here to kick this off. Is it  
11 my understanding that this requirement of sort of  
12 canceling a cohort would only apply to ones that  
13 had been added sort of from this point on? It  
14 would not apply to those original four?

15 **MR. KATZ:** No, there's no authority to  
16 address the cohorts that were established by the  
17 law.

18 **DR. ZIEMER:** By the law itself.

19 **MR. KATZ:** Right.

20 **DR. ZIEMER:** Thank you.

21 **MR. KATZ:** That's correct.

22 **DR. ZIEMER:** Let's ask for other questions.  
23 Okay, Roy.

24 **DR. DEHART:** If I or a group had had their  
25 estimate of exposure reviewed by individual

1 submission, you deny it, I come back then and  
2 petition as a special cohort, which I expect  
3 would be common. Is that correct, I could do  
4 that?

5 **MR. KATZ:** You could -- you could come back  
6 --

7 **DR. DEHART:** Saying that you didn't really  
8 have sufficient data of my exposure?

9 **MR. KATZ:** Let me clarify, though. There's  
10 nothing barring you from petitioning. The issue  
11 is that you will have already, I assume, then  
12 appealed your dose reconstruction since you  
13 differ with its results or its feasibility, in  
14 effect, what you're saying. You will already  
15 have appealed that to the Department of Labor,  
16 and if there were substantial grounds we would  
17 have already reconsidered that dose  
18 reconstruction under the dose reconstruction  
19 rule. Those provisions are provided.

20 So you're saying after you've done all that  
21 and then you're denied, your claim is still  
22 denied by DOL, then you would come back and  
23 petition, and yes, you could. But lacking --  
24 unless you can provide information that wasn't  
25 provided before to make your case, it seems like

1 that would be an open-and-shut case, in effect.  
2 We've done your dose reconstruction. We can do  
3 it. And if you provide no reason for us to  
4 believe that information wasn't available, then -  
5 -

6 **DR. DEHART:** If I read the *Federal Record*  
7 (sic) correctly, there was a statement that a  
8 petitioner's statement now becomes a matter of  
9 fact, which it would not have been earlier.

10 **MR. KATZ:** I'm not following you. I'm not  
11 following you.

12 **DR. DEHART:** If I had said I had been exposed  
13 to a situation where I'm stating I had 15 R  
14 exposure, you could not validate that earlier on  
15 in the process so that there's no evidence that I  
16 had sufficient exposure to qualify. Now I could  
17 come back as a petitioner under this system, and  
18 as I read this the implication was if I simply  
19 state that I had had an exposure, that becomes  
20 sufficient evidence for consideration.

21 **MR. KATZ:** Well, there would have to be  
22 records to support that.

23 **DR. DEHART:** I wasn't sure that that was  
24 stated in the -- I'll see if I can find that  
25 specific statement.

1           **DR. ZIEMER:** You're asking whether simply  
2 asserting that you were exposed is sufficient --

3           **DR. DEHART:** Yes.

4           **DR. ZIEMER:** -- grounds.

5           And Ted, as I understand it, there would have  
6 to be -- even if you couldn't reconstruct the  
7 dose there would have to be, for example, some  
8 evidence that there were sources around or  
9 something like that.

10           **MR. KATZ:** We would have to, with certain  
11 specificity, identify what those sources were,  
12 what occurred, and so on.

13           **DR. DEHART:** Yes, I understand that.

14           **MR. KATZ:** And you're saying that someone  
15 could do that, then?

16           **DR. DEHART:** Correct.

17           **MR. KATZ:** And specify those, and they would  
18 make the first hurdle. And that's true, I think.

19           **DR. ZIEMER:** Jim.

20           **DR. MELIUS:** Ted and Larry have heard this  
21 already, at least parts of it, but my major  
22 concern about this approach is -- and it goes  
23 back to when we were doing the dose  
24 reconstruction rule also, and the guidelines for  
25 that -- is that we have not established any

1 guidelines for when a dose reconstruction is not  
2 of sufficient quality to sort of pass muster,  
3 whatever you want to call that, and that there  
4 are no criteria for that that have been  
5 established nor any real guidelines. And if I  
6 remember correctly -- it goes back a couple of  
7 meetings -- I think Jim Neton said they were  
8 going to eventually develop some sort of  
9 guidelines or consideration. But we don't have  
10 those yet. We've based a whole rule on this sort  
11 of nebulous case-by-case approach that we will --  
12 there'll be a determination that there's not  
13 sufficient information, whatever, in order to be  
14 able to do a quality dose reconstruction.

15           However, at the same time we're saying that  
16 there ought to be enough information that we can  
17 do this reasonable likelihood dose reconstruction  
18 in order to make sure whether the class would  
19 fit. So it meets some criteria, but it doesn't  
20 meet the criteria for individual dose  
21 reconstruction. And I believe that without any  
22 sort of guidelines or parameters on this that  
23 we're getting into a very murky area. One could  
24 see situations, depending on who in the class  
25 applied, how we could come up with very different

1 decisions that we really -- that the scientific  
2 quality of what's being done in terms of the dose  
3 reconstructions would be quite variable because  
4 we'd be at the edges of where there's adequate  
5 information to do that.

6 I'm not sure that as we've talked about a  
7 review process by the Board that we've even set  
8 up a scheme that would capture those where a bad  
9 dose -- a poor quality dose reconstruction's been  
10 done for a person, how -- we're going to sort of  
11 pick those up randomly. And rather, as opposed  
12 to a situation where we -- because of the absence  
13 of criteria, we really don't know when the  
14 criteria is between a bad dose reconstruction --  
15 where's the line between a bad dose  
16 reconstruction and an admission that there is not  
17 enough quality information to do a dose  
18 reconstruction?

19 And then in between that we set up this third  
20 parameter, this reasonable likelihood calculation  
21 that's going to be done that somehow fits in  
22 between those two, and we're doing all of that  
23 without any really established criteria for doing  
24 that. It's all case-by-case basis. And I find  
25 that very troubling to this whole process, that

1           until we've established some criteria for when  
2           there's not adequate information to do a quality  
3           dose reconstruction that this whole process  
4           becomes very arbitrary and very unfair to the  
5           applicants, and very hard to have it transparent  
6           for people on the outside to know what to do.

7           Carry that over another step to the  
8           petitioning process: How do you know when you  
9           have -- when there's poor enough information that  
10          you would qualify under the petitioning process?  
11          And again, we've not established the criteria or  
12          the guidelines for doing that. I think that's a  
13          major hole in this whole process as it's being  
14          proposed here.

15          **DR. ZIEMER:** Let me comment in part on that.  
16          It seems to me we have to be careful when we talk  
17          about sort of quality dose reconstruction.  
18          Actually, the methodology has built into it the  
19          issue of uncertainty. And so under the scheme  
20          that's proposed, you could do something that I  
21          might call a quality dose reconstruction that has  
22          a lot of uncertainty because there's uncertainty  
23          in the data, there's missing data, and there are  
24          provisions for handling this.

25          So in fact, what someone might call a poor

1 quality -- in terms of getting the right number -  
2 - I think we find out in many cases actually  
3 favors the claimant, because the uncertainty gets  
4 larger, and that almost in every case that I've  
5 looked at helps the claimant as the uncertainty  
6 gets larger. If there is dosimetry data  
7 available -- and you can say what you will about  
8 its quality, but presumably the quality of that  
9 gets reflected, in a sense, in that uncertainty  
10 information, which includes the calibration  
11 methods, the limits of detection, and all that  
12 sort of thing.

13 It seems to me what you're talking about here  
14 is a case where there's virtually no dose  
15 information. You have some knowledge that there  
16 were certain kinds of sources around. And I can  
17 think of cases where if someone said I know that  
18 we had this ten microcurie carbon 14 source and  
19 nobody was wearing film badges, and therefore I'm  
20 going to make a claim, and a reasonable person  
21 could do a calculation and show that it doesn't  
22 matter what you did with that, there's no way  
23 you're going to get a dose above some value, even  
24 if you ate it all. So you can do those upper  
25 boundaries with no dosimetry and no monitoring

1 data and do that.

2 So I think in principle you can do the things  
3 you're talking about. What turns out is that we  
4 don't know all those cases, and that makes us  
5 very leery. Do we really have the tools to  
6 address all these, and we haven't defined all the  
7 parameters.

8 **DR. MELIUS:** That's my point, is that we  
9 haven't made -- defined the parameters --

10 **DR. ZIEMER:** And can you, without knowing  
11 what they are, can you do that in advance, yeah.

12 **DR. MELIUS:** Well, I think you can. I think  
13 you can do some of it, and quality, I'm trying to  
14 use it in a broad sense because it includes  
15 availability of information.

16 **DR. ZIEMER:** Right.

17 **DR. MELIUS:** And the other issue that comes  
18 raised is feasibility. How feasible is it to go  
19 down and track down all -- how much time and  
20 effort will it take to track down and obtain all  
21 this information, and how do we judge the effort  
22 that NIOSH has made and that the people holding  
23 the records have made to --

24 **DR. ZIEMER:** Right. And I think that's where  
25 most of us have a little more apprehension. Do

1 we really have the information that we need --

2 **DR. MELIUS:** Yeah, and so --

3 **DR. ZIEMER:** -- to make the judgment.

4 **DR. MELIUS:** Yeah. But somehow we're setting  
5 up this scheme that will do a -- say we can't do  
6 a dose reconstruction, yet we can do enough of a  
7 dose reconstruction to do this reasonable  
8 likelihood estimate; and then in other cases we  
9 can do a dose reconstruction. And where are the  
10 parameters that will determine how those do --  
11 and I understand it's complicated and so forth,  
12 and we can say it's case-by-case. But I think  
13 there has to be some rules and some guidelines on  
14 how this is going to be -- both to make the  
15 program, as I say, work, and not arbitrarily make  
16 these decisions.

17 **MR. KATZ:** Can I just respond a little bit to  
18 part of that? Part of that is there to the  
19 extent that it can be there, is the reasonable  
20 likelihood is -- it's fairly clearly stated how  
21 you would use NIOSH-IREP. And then in terms of  
22 how you make a determination as to whether  
23 radiation doses could have exceeded that  
24 threshold is, as it's discussed in the rule, is a  
25 subjective decision. It's a subjective judgment.

1 But it is a judgment that is made openly and  
2 presented to the Board, and considered by the  
3 Board as to whether it's reasonable to consider  
4 that these radiation sources could have caused  
5 such a high level and so on, given what's not  
6 known about the process and so on.

7 So I think it's the best you can do in this  
8 circumstances of lack of information, is have a  
9 subjective decision that is open to scrutiny  
10 because there's no decision logic you could drive  
11 this by that would simply be a sort of factual  
12 open-and-shut case. Or that we have been unable  
13 to imagine it, is what I should say, and if the  
14 public presents with us a better solution for  
15 addressing this sort of murky area we will lunge  
16 at it, I'm sure.

17 **DR. ZIEMER:** Henry.

18 **DR. ANDERSON:** Yeah, I got kind of a -- two  
19 different issues. It seems to me that most of  
20 the focus of the rule is on people coming in via  
21 the filed claims mechanism, and I think that's  
22 where we're having some of this trouble, that we  
23 don't know -- you file a claim, where exactly  
24 will the claim -- what are the parameters that'll  
25 say we can't reconstruct it? And then based on

1 that lack of ability to reconstruct, will we be  
2 able to meet the likelihood issue? Because if  
3 you had the likelihood issue, your parameters  
4 would be such that you probably could estimate.

5 So coming in through a claim, then to me the  
6 issue would be, okay, if you get that, then is  
7 this person a accurate reflection of the class of  
8 people? Because I could see -- at least I don't  
9 see anywhere that it says that to be a class,  
10 everybody in that class can't have their dose --  
11 the ability to be reconstructed. So it seems to  
12 me you could begin to get a sense of some classes  
13 where some of the individuals are borderline and  
14 others would not be. And so it's one of a  
15 streamlining process coming in through that  
16 system.

17 Now I could see -- my question is, so let's  
18 take a look at what would you anticipate as a  
19 hypothetical class that isn't currently a part of  
20 the system to not have to go through this? And  
21 then can we define those kind of people so that  
22 you now have a definition of a class, and then  
23 when somebody comes in you see whether they fit  
24 that class rather than having to go through the  
25 dose reconstruction. It would seem to me the

1 kind of -- and I'd ask, so what classes do you  
2 think are reasonably out there that might fit  
3 this kind of parameter?

4 And it would seem to me you might have  
5 accidents or unanticipated events that were not  
6 monitored and measured that could have delivered  
7 a significant dose, so you could then define here  
8 are the kind of parameters that this class would  
9 fit. And your measurement would be not can they  
10 be dose-reconstructed, but -- as is now -- if you  
11 meet the class, you're in the class for the  
12 selected 22 cancers. And again, the averaging  
13 and all of this kind of thing, what I think you  
14 have to look at, what are the hypothetical  
15 classes out there?

16 And it seems that's a process that's a little  
17 easier than -- to do than wait for an individual  
18 to then say, well, is this a sentinel event for a  
19 class, rather than trying to define those classes  
20 up front, and are there circumstances where you  
21 wouldn't expect there to have been anybody  
22 monitoring because you're into an emergency  
23 response kind of activity? Are there -- can  
24 NIOSH think of any classes, hypothetically, that  
25 might be out there? And it might be easier to

1           come at it from defining those classes, getting  
2           those petitions going before you've got a  
3           potential person coming in. Because to me then  
4           the process would be does the person meet the  
5           class, rather than can we reconstruct the dose  
6           for this person; and then secondarily, are they  
7           in a class?

8           Now if they came in with a cancer that isn't  
9           part of the special cohort, then obviously you  
10          would go through the -- they could get  
11          compensated based on exposure. So to come in  
12          every time through we can't do your dose, so  
13          therefore you would then be looked at to see if  
14          you're part of the class, I would turn that  
15          around and say can we or are there things that we  
16          ought to be looking at, establishing those  
17          classes, before we have any claims filed of  
18          individuals.

19          **MR. KATZ:** A just partial response to that.  
20          If we thought we could define the classes up  
21          front, we'd be in great shape. We don't think we  
22          can. And just to take an example you outlined,  
23          exposure incidents, special exposure incidents,  
24          in some cases there is monitoring and you do have  
25          records, and you can reconstruct the doses from

1 those incidents; and in other cases you can't.  
2 You can't -- there's no happy category,  
3 unfortunately, of class that stands on its own,  
4 which is why we're left with case-by-case.

5 Now there are situations -- I think there are  
6 some situations we know about which we think hold  
7 real potential as classes, and Jim could talk  
8 about one of those if you want to hear an  
9 example. But it is a problem because we can't  
10 define the classes up front.

11 **DR. ANDERSON:** See, I -- then what you're  
12 doing is you're now defining classes of one, is  
13 really what it is. As individuals file claims  
14 that can't be reconstructed, they then become a  
15 class of one because somebody else who meets the  
16 same parameters might well be able to be dose-  
17 reconstructed. And that I see as the potential  
18 problem in the thing.

19 **MR. KATZ:** Can I respond?

20 **DR. ANDERSON:** Because you can't -- does  
21 everybody in the class have to not be able to  
22 have their doses reconstructed?

23 **MR. KATZ:** And the answer, I think, to that  
24 is yes, because you can reconstruct a person's  
25 dose by their co-workers' experience if they have

1 the same exposure experience. That's a standard  
2 approach in dose reconstruction to use. So in  
3 that case, where you have the same exposure  
4 conditions, the same circumstances, the co-  
5 workers' data would be good enough to reconstruct  
6 the dose for that individual.

7 But as far as establishing classes of one,  
8 again, as you said, it's a sentinel there. We  
9 don't stop with the one individual who we  
10 couldn't reconstruct their dose. That's a  
11 starting point for us to determine how many  
12 others are in the same situation as that  
13 individual and thus should be added to that class  
14 definition, which is why I explained that the  
15 initial definition going forward from the  
16 petition isn't necessarily the definition that  
17 comes out the other end.

18 **DR. ANDERSON:** A last question. The current  
19 special cohorts, are you saying that in those  
20 special cohorts nobody can have their dose  
21 reconstructed?

22 **MR. KATZ:** Absolutely not. And actually it  
23 was very explicit in our dose reconstruction rule  
24 that we would be considering those cases when  
25 they don't have one of the 22 specified cancers,

1 because in their cases, if they can't have a dose  
2 reconstruction, they're out of luck. They have  
3 no remedy. So we will be attempting dose  
4 reconstructions, we're sure. I don't know if  
5 we've received any yet. I think we -- yes, we  
6 have; Larry's indicating we have. We've received  
7 requests for dose reconstructions from  
8 individuals who are part of that established  
9 Congressional Special Exposure Cohort.

10 **DR. ZIEMER:** And keep in mind, those were  
11 identified by Congress --

12 **MR. KATZ:** Right.

13 **DR. ZIEMER:** -- regardless of --

14 **DR. ANDERSON:** I know, but what I'm getting  
15 at is on a fairness issue one might want to look  
16 at is there going to be a same level -- can we  
17 use those groups as a comparison to say, okay,  
18 they were put in that way, we have some  
19 understanding of exposures there, and why they  
20 were considered. And then do we -- can we apply  
21 those kind -- use that to generate criteria for  
22 the other, or are we setting a different hurdle  
23 for the hypothetical group?

24 **DR. ZIEMER:** My evaluation is that the law  
25 has already set a different hurdle the way it is

1 written. The fact of the matter is because there  
2 are people at other plants that say, why wasn't I  
3 included because what we do is similar to what  
4 they did or worse. So I'm not sure that fairness  
5 in itself is the criteria that's -- one can argue  
6 how is the law fair the way it's written.

7 **DR. MELIUS:** Let me just understand another  
8 approach on this. If these are all classes of  
9 one, then aren't you really just saying -- one  
10 approach would be that if a person -- you can't  
11 reconstruct their dose. You would then do the  
12 reasonable likelihood calculation for them, and  
13 then if they pass that then they're --

14 **UNIDENTIFIED:** They're compensated.

15 **DR. MELIUS:** -- they're compensated, if they  
16 have one of the appropriate cancers. And then  
17 they have to go through the process up through  
18 the Secretary, et cetera, et cetera. But it's --  
19 we go through the different scenarios. That's  
20 going to be one scenario.

21 Another scenario is how fine tuning do you  
22 get in terms of within what's the class? Because  
23 if you can't do it for person A, but person B who  
24 worked beside them, there was enough information  
25 but you didn't have that information at the time

1 you were doing person A, then you're going to  
2 have -- person B gets dose reconstructed, person  
3 A doesn't. Well, is person A and B, are they  
4 different classes, or how do you do that? It  
5 seems to me this gets awfully complicated. And  
6 again, my concern is either it takes an awfully  
7 long time to sort this all out, people aren't  
8 going to get compensated for many years, or it's  
9 going to become very arbitrary as to who within a  
10 group will get compensated and who won't.

11 **DR. ZIEMER:** Ted has the answer to that.

12 **MR. KATZ:** Just a partial answer there.  
13 Person A, we've done it, we've said we couldn't  
14 do a dose reconstruction and then we attempt to  
15 do Special Exposure Cohort, and now you're saying  
16 we look at person B and determine we can do a  
17 dose reconstruction. When we're doing the dose  
18 reconstructions, one of the things we'll be doing  
19 is looking at co-workers in the first place,  
20 because that would be an avenue for being able to  
21 do the dose reconstruction. So we'll have done a  
22 lot of work in determining, in effect, the  
23 parameters of the class when we attempted to do  
24 that individual dose reconstruction, which is  
25 part of the reason it'll be more efficient once

1 we have done that work to go forward.

2 But if we were in circumstances -- I guess  
3 this is the other thing you might have been  
4 raising -- is as we go forward with the Special  
5 Exposure Cohort petition, we do a lot of work,  
6 something turns up and we find out we can do dose  
7 reconstructions for person A, who kicked this off  
8 in effect -- we told him we couldn't do a dose  
9 reconstruction -- at that point we would be going  
10 back and then doing a dose reconstruction for  
11 person A. Again, it's not about establishing  
12 classes of one. It's about, as Dr. Anderson  
13 said, they in effect work as sentinels for us to  
14 know we have a problem in a group of workers for  
15 whom there's a likelihood that they should be  
16 added to the Special Exposure Cohort.

17 **DR. MELIUS:** I have one other related issue,  
18 and it goes back to our review process on these  
19 dose reconstructions. It would seem to me that  
20 if this approach were the approach that's  
21 followed, that people that can't have a dose  
22 reconstructed or close to not having their dose  
23 reconstructed become the ones we really become  
24 very concerned about. And that it behooves us to  
25 have a review process that captures many, if not

1 all, of those where there's real uncertainty or -  
2 - I don't know what the right term, uncertainty  
3 isn't the right word here because it -- but say  
4 there's real difficulty, and the persons on a  
5 borderline between having their dose  
6 reconstructed and not, that it would behoove us  
7 as this Board to be very careful reviewing those  
8 because those are going to have some major  
9 implications in terms of decisions for that  
10 individual as well as for -- potentially for a  
11 large class of people where the information is  
12 marginal.

13 And how are we going to have a process of --  
14 are we going to be willing to first review all  
15 that number -- and again, at this point it's hard  
16 to tell what that number will be, but certainly a  
17 sizeable number of people out of the 5-, 10-,  
18 20,000, whatever claims are out there right now.  
19 And how do we have a system that identifies  
20 those, because it's going to be hard to identify  
21 without criteria set up or guidelines set up that  
22 will sort of guide this process in some way.

23 **DR. ZIEMER:** I'd like to comment on that  
24 part, too, at this point. Just one of the  
25 concerns that I have as I read through the

1 proposed rule is the future role of this Board in  
2 terms of time commitments. I don't think we have  
3 a feel yet for numbers of cases. It looks like  
4 many of these could come before this Board, and  
5 we could be spending a lot of time as a Board  
6 adjudicating cases.

7 Do we have any feel at this point for what  
8 this is going to look like? Let's say that a  
9 year from now that we have our other things in  
10 place and we're monitoring the dose  
11 reconstructions and so on, and some of this kicks  
12 in. Does anybody have a feel for what we're  
13 talking about here? It may be too early to even  
14 know, but this rule-making has a lot of  
15 involvement of this Board in the process, and --

16 **DR. ANDERSON:** And we don't know how many.

17 **DR. ZIEMER:** Well, we can come back to this.  
18 But I don't know if the staff even -- do you have  
19 any sort of early thoughts on that, what that's  
20 going to mean?

21 **MR. KATZ:** I'll be glad to address that, but  
22 it's not very helpful because it's entirely  
23 speculative. And in some respects the design of  
24 the ultimate final rule will have a bearing on  
25 how many petitions there are as well. But for

1 the purposes of this notice of proposed rule-  
2 making, we estimated I believe around -- that  
3 there would be 90 petitions a year we would be,  
4 on average, addressing. And that was  
5 predominantly then petitions that are coming as a  
6 result of not being able to do complete dose  
7 reconstructions, and then others that are brought  
8 on initiative without that being a parameter.

9 **DR. ZIEMER:** It might be helpful -- and take  
10 a number, say it's 90. You may be off one way or  
11 the other by a great deal. But if there were 90,  
12 for example, what are the implications of that in  
13 terms of sort of the caseload of this group? We  
14 need to think about that.

15 **MR. ELLIOTT:** You're going to see every one  
16 of them.

17 **MR. KATZ:** Yeah, the way this is written.

18 **DR. ANDERSON:** At an hour apiece, that's a  
19 lot.

20 **MR. KATZ:** And that's a requirement of the  
21 law that you see these.

22 **MR. ELLIOTT:** Ted's certainly correct in his  
23 statement that until we see what the final rule  
24 looks like and what the process is stated to be  
25 in the final rule, it's hard for us to predict.

1 It's speculative now. But perhaps this will  
2 inform, to a certain extent, your question.

3 We have heard from various entities that they  
4 have an interest in filing a petition, an  
5 interest on behalf of construction workers,  
6 construction workers across the complex,  
7 construction workers at a given site; interest  
8 here in Rocky Flats, for what -- on behalf of  
9 what class, I'm not sure; interest in Los Alamos  
10 on behalf of the folks who worked in -- I forget  
11 the technical area, but the dump area.

12 **MR. ESPINOSA:** Area G.

13 **MR. ELLIOTT:** Area G, okay. Army ammunition  
14 plant at Iowa, there's a huge interest out there  
15 because of the complex situation where Department  
16 of Defense and Department of Energy shared space,  
17 et cetera. There's a large amount of confusion  
18 about, in that particular instance, about where  
19 we think we can do dose reconstruction and where  
20 they're not so sure we can. We have heard of  
21 interest in Oak Ridge. I believe that's pretty  
22 much the extent of the interest that's been  
23 expressed.

24 Now what fruit comes from those expressed  
25 interests, I can't predict at this point in time.

1 We'll have to wait and see what the final rule  
2 looks like, what the process stipulates, before  
3 we can actually see how many petitions come  
4 forward.

5 **DR. ANDERSON:** Just one thought that some of  
6 us had is, is it possible to go with an interim  
7 rule? Since we really don't have a good -- I  
8 mean, it's all speculative at this point and we  
9 can go 'round and 'round. But one way, when  
10 you're uncertain as to the workload here, would  
11 be to have this be an interim rule that sunsets  
12 or has to be finalized in three years, so we have  
13 some track record to take a look at it rather  
14 than having it be final, and then kind of the  
15 hurdle to have to go back to reopen it becomes  
16 much more difficult than it if it's --

17 **MR. ELLIOTT:** There's more -- I'll let Ted  
18 speak to this as well -- but there's more  
19 problems with going forward with an interim final  
20 rule where you can actually do work, as we did on  
21 the dose reconstruction rule. Because if we work  
22 on a petition, and let's say we come out with --  
23 the Secretary makes a decision, and then once the  
24 rule becomes final and how it looks and what the  
25 process is established in the final rule, we may

1 end up revisiting those petitions that were  
2 worked on in that process. So I think there's an  
3 interest within the Department and the  
4 Secretary's Office of this approach of a notice  
5 of proposed rule-making to get all of the --  
6 thrash out the public comment and the interests  
7 and the concerns that are being identified.

8 Ted, you want to add to that?

9 **MR. KATZ:** Well, I just -- I'm sorry. I'm  
10 just trying to understand what Dr. Anderson's  
11 saying better. But are you talking about then  
12 the next step being -- we've made a notice of  
13 proposed rule-making, the next step being issuing  
14 an interim rule, interim final rule as opposed to  
15 a final rule? Is that what you were asking?

16 **DR. ANDERSON:** Yeah, and then you have --

17 **MR. KATZ:** Yes. No, I understand. I  
18 understand. And that's certainly a --

19 **DR. ANDERSON:** Because you may want to  
20 revisit them. The whole point of it is we don't  
21 have experience. It's all speculative at this  
22 point, so we don't know how many or whatever, how  
23 well this -- and if you get a lot of public  
24 comment that, gee, this is all very subjective, a  
25 way to approach that is, well, let's get some

1 experience. I'm just raising that as one --

2 **DR. ZIEMER:** Jim, you have another comment?

3 **DR. MELIUS:** I have two points. I don't know  
4 when you're planning on announcing it, but in  
5 terms of public comment, I believe there is a  
6 plan for some stakeholders, additional  
7 stakeholder meetings? Is that --

8 **MR. KATZ:** Yes, that's correct.

9 **DR. MELIUS:** Can you sort of tell us about  
10 those?

11 **MR. KATZ:** Yeah. I can tell you --

12 **DR. MELIUS:** And then I have a follow-up  
13 question.

14 **MR. KATZ:** I can tell you that the details  
15 aren't settled, but we are planning -- well, for  
16 good reason, the whole issue of doing stakeholder  
17 meetings just arose recently. But we are  
18 planning to have four meetings, local meetings at  
19 sites where we expect there would be people would  
20 have an interest in petitions. And we haven't  
21 settled the details as to which sites they would  
22 be. We've had a general discussion of that, and  
23 we've raised sites as possibilities.

24 Larry, do you want me to run through those  
25 possibilities?

1           The possibilities that we're considering --  
2           and we're open to input on these, most certainly  
3           -- are Hanford in Washington State, and Los  
4           Alamos area, and thirdly, the New  
5           York/Pennsylvania area. The Department of Labor  
6           did this in Buffalo because there are a lot of  
7           sites around Buffalo. So whether that is the  
8           right location exactly, there are a lot of AWEs  
9           in that area, which is the reason why that might  
10          be appealing, because they also may have lots of  
11          records problems. And the fourth site -- there  
12          were several discussed -- and I believe the  
13          Savannah River site was one that was discussed,  
14          because there are a lot of claims under the  
15          EEOICPA right now that are coming from Savannah  
16          River site.

17                 And the other one, Larry, is either Rocky  
18          Flats or Fernald, I believe?

19                 **MR. ELLIOTT:** We talked earlier about Oak  
20          Ridge.

21                 **MR. KATZ:** Oak Ridge, I'm sorry.

22                 **DR. MELIUS:** Your plan is to do these --

23                 **MR. KATZ:** Our plan is to do these within 45  
24          days of the comment period, to include these  
25          within 45 days of the comment period, which means

1 that in effect we would have to set these up to  
2 be able to do these at the end of July and the  
3 very beginning of August. Which is soon.

4 **DR. MELIUS:** Anyway, the Board -- we should  
5 take that into consideration developing our  
6 comments.

7 My question actually goes back to the last  
8 Board meeting. I believe at that time these were  
9 guidelines, not formalized rule-making procedure.  
10 It was going to be a set of policy or guidelines  
11 coming from the Secretary, and I believe you  
12 mentioned at that meeting that there was some  
13 differences of opinion, or you're trying to make  
14 up your mind to do that. But I was just  
15 wondering if someone could sort of tell us a  
16 little bit more about the difference, and  
17 particularly in relationship to Henry's question  
18 about interim rule, and do these need to be --  
19 does this need to be done by rule-making as  
20 formal regulation? Why is that? What changed in  
21 the process that --

22 **MR. KATZ:** I'll be glad to address that to  
23 the extent I'm able. And if the HHS lawyers want  
24 to clarify they might, but I think I understand  
25 this well enough.

1           This does not have to be done by rule-making,  
2           that is correct. The law, EEOICPA, does not  
3           require us to do this by rule-making. The  
4           problem lies in producing procedures that are  
5           binding on HHS. In effect, you end up producing  
6           something that walks and talks like a rule, and  
7           if it walks and talks like a rule there's legal  
8           history to support that it needs to be a rule,  
9           and that ends up being part of the issue.

10           HHS intended to go down the guideline route  
11           as opposed to issuing a rule because -- precisely  
12           because of the issue that you're all wrestling  
13           with right now, because there's a whole lot of  
14           uncertainty about what's going to be coming in  
15           and how and so on. And all that uncertainty, I  
16           think, HHS wanted more flexibility to address  
17           that than they have when they issue a rule, which  
18           is binding. But in reality, the procedures we've  
19           produced walk and talk like a rule, and hence we  
20           needed to issue a rule.

21           Now the difference between interim final rule  
22           and a final rule, in effect -- there's no  
23           difference in terms of the way they bind the  
24           Agency and so on. They're treated the same under  
25           the law. But the issue is simply you save a step

1 when you issue an interim final rule if you're  
2 going to go about changing it down the road,  
3 because if you issue a final rule then you would  
4 after that have to issue a notice of proposed  
5 rule-making again before you go issue a change in  
6 that final rule. Whereas if you issue an interim  
7 final rule and have comments on that again, so  
8 that would be a second period of comments, then  
9 you could immediately afterwards, so long as you  
10 stayed within sort of the scope of what you asked  
11 for comments for and the information that was  
12 available to the public, you could then issue a  
13 final rule immediately without having to go  
14 through an extra step.

15 I'm sorry this is long-winded, but --

16 **DR. MELIUS:** That's helpful. The lawyers  
17 didn't jump up and down, so that's a good sign.

18 (Laughter)

19 **DR. ZIEMER:** We're going to have more time  
20 after lunch to address this further, so I'm going  
21 to call for a recess here in just a moment.

22 I do want to tell you that again we don't  
23 have group lunch or plans for a group lunch.  
24 There are many restaurants in this area. There's  
25 a list of --

1 Cori, where are you?

2 **MS. HOMER:** I'm back here.

3 **DR. ZIEMER:** Okay. You have copies of all  
4 these downtown Denver restaurants. I don't see  
5 addresses on this, but there are names and  
6 indication of whether they take big bucks or  
7 little bucks to eat there. I guess the concierge  
8 desk has information on how to get to some of  
9 these, but there's probably two dozen restaurants  
10 around here close by.

11 Our experience has been that when we do go  
12 outside the hotel, which many may wish to do,  
13 it's a little hard to get served and back within  
14 an hour. So I'm going to suggest that we  
15 reconvene at 1:15; 1:15 will be our target for  
16 reconvening. And if the Chairman gets back from  
17 lunch by then, then we'll reconvene.

18 Are there any other housekeeping  
19 announcements we need to make before we recess?

20 **MS. HOMER:** I would suggest everybody take  
21 anything that's worth anything to you. Take it  
22 with you or lock it up, because the room cannot  
23 be secured while we're gone.

24 **DR. ZIEMER:** And that means what, like  
25 laptops?



1 asks people to comment on. You recall the other  
2 two rule-makings, there were some very specific  
3 questions they asked commenters to address. That  
4 is not the case here. So as we think about what  
5 form our comments might take, let me start by  
6 implanting some seeds of ideas.

7 We might think about whether or not there are  
8 technical issues that we wish to address,  
9 technical or scientific issues. Are there  
10 procedural issues that we wish to address? Are  
11 there questions that we want to identify that we  
12 think should be answered, sort of parallel to the  
13 general questions that were asked of the other  
14 rule-making items? And then I would ask whether  
15 or not at some point this Board feels that it can  
16 make an overarching statement about the rule-  
17 making, that if the following issues are  
18 addressed, then this rule-making would be  
19 considered to be, for example, acceptable or  
20 something like that.

21 Now I don't want to lay out a format at this  
22 point as to how this ought to be or should be  
23 addressed. I think -- I want to be completely  
24 open on this. So let's think about whether or  
25 not we can identify issues that we think need to

1 be addressed in some way or another, without  
2 doing any -- just identify sort of categorically  
3 what needs to be addressed in here in some way  
4 that would help with your comfort level.

5 **DR. ROESSLER:** Before we get there, I don't  
6 seem to find that. Is that in the packet?

7 **DR. ZIEMER:** This I downloaded from the web  
8 site.

9 **DR. ROESSLER:** Ah.

10 **DR. ZIEMER:** You have this in your packet in  
11 the form in which it was submitted to the -- oh,  
12 is it in there?

13 **UNIDENTIFIED:** (Inaudible)

14 **DR. ZIEMER:** Yeah, but it's in the  
15 typewritten form rather than the *Federal Register*  
16 form.

17 **DR. ROESSLER:** I downloaded half of it and my  
18 printer quit.

19 **DR. ZIEMER:** The nice thing about the *Federal*  
20 *Register* version is that rather than 64 pages  
21 it's more like -- yeah, not so many pages. But  
22 otherwise, as far as I know, it's the same stuff.

23

24 So is anyone ready to start thinking about  
25 issues that we need to talk about?

1 Jim, kick us off.

2 **DR. MELIUS:** I think there are two general  
3 questions. They are somewhat related, but one is  
4 that this rule-making puts an emphasis -- the  
5 approach is the emphasis on individual dose  
6 reconstruction as a way of generating Special  
7 Exposure Cohort members, as opposed to an  
8 approach that relies on group petitions. And I  
9 think there's some pluses and minuses to those  
10 approaches, and to some extent they're  
11 complementary. But I think we ought to discuss  
12 is that the proper approach.

13 The second issue, general issue, is one I  
14 raised earlier, is this whole issue of the lack  
15 of any definition or guidance on or parameters  
16 covering when can a dose not be reconstructed  
17 with sufficient quality, et cetera, for the  
18 purposes of this program. And I think that just  
19 raises a whole host of scientific and procedural  
20 issues within this rule-making, but should that  
21 be addressed, it would really change the whole  
22 approach.

23 **DR. ZIEMER:** Thank you.

24 Other -- let's just get items out on the  
25 floor here.

1 Sally.

2 **MS. GADOLA:** I have some questions as to some  
3 of their definitions and why things are stated  
4 the way they are stated. One of my particular  
5 ones was about ill effects -- not quoting it  
6 exactly -- but it just has to do with radiation  
7 and cancer, and at the beginning it also talks  
8 about silicosis and beryllium. And my direct  
9 question was some areas appear to have more cases  
10 of silicosis, and why are they not considered a  
11 special cohort?

12 Which leads me back to another question that  
13 I think we should ask, is how did they determine  
14 special cohorts to start with? Why are certain  
15 people at K-25 with bladder cancer in a special  
16 cohort?

17 **DR. ZIEMER:** Does anyone wish to actually  
18 answer that question, other than the fact that  
19 that's what Congress decided?

20 **MS. GADOLA:** It helps us to establish new  
21 ones if we know how they did the old ones.

22 **DR. ZIEMER:** Well --

23 **MS. GADOLA:** I think NIOSH would be in the  
24 best position to determine if it was done by what  
25 I sort of suspect, is if you have a large

1 percentage of workers that worked in a particular  
2 area that developed a particular type of cancer.  
3 So if you're getting a lot of claims for a  
4 certain type of cancer from a certain area or  
5 during a certain time period, then that would  
6 indicate that there's definitely a problem there.  
7 And it would seem that that might be one of the  
8 criteria to say this should be a special cohort.  
9 Any comments?

10 **DR. ZIEMER:** Maybe the staff can help on  
11 this, but it's my understanding that the way the  
12 law is written now, if you can do dose  
13 reconstruction on those that would preclude the  
14 special cohort.

15 Is that correct?

16 **UNIDENTIFIED:** Yes.

17 **DR. ZIEMER:** Yes. Even -- right.

18 **MS. GADOLA:** But if you get a bunch of claims  
19 and you can't prove it, you can't reconstruct the  
20 dosage but you're still getting a lot of claims  
21 from that area for that type of cancer, then it  
22 would give you a clue that something happened  
23 there.

24 That brings up another question that I have  
25 on this specific rule because it states who can

1 bring this to our attention, and one of the  
2 groups that was recognized was the unions. And I  
3 was wondering if there were not other groups that  
4 should be included. And I was trying to think,  
5 well, who might these other groups be? And I  
6 thought perhaps health care providers might  
7 notice that they had a certain type of high rate  
8 of cancer from workers in a particular area that  
9 worked at a particular plant during a certain  
10 time.

11 **MR. PRESLEY:** We have retiree organizations,  
12 too, that ought to be able to come out and -- but  
13 I have a question --

14 **DR. ZIEMER:** Before you ask your question, is  
15 there anything that would exclude the other  
16 groups? This doesn't preclude other groups, does  
17 it?

18 **MR. KATZ:** From petitioning?

19 **DR. ZIEMER:** Yeah.

20 **MR. KATZ:** I'm sorry, it's Ted Katz. Yes, it  
21 does. The rule limits petitions to be submitted  
22 by either employees, survivors of employees, or  
23 unions. It does preclude other groups from  
24 submitting the petition. But it does discuss  
25 this to some extent in saying that because the

1 petitions are supposed to be by employees, and  
2 that's what we're trying to define, but it does  
3 go on to express that there are other parties  
4 that may have expertise in those cases. They  
5 need to get together with people who might be  
6 petitioners and simply assist them in  
7 petitioning, but they would not be the name on  
8 the petition in effect.

9 **DR. ZIEMER:** They could not petition on  
10 behalf of an employee group since they don't  
11 represent them per se, is what you're saying?  
12 Other than the union groups?

13 **MR. KATZ:** That is what I'm saying.

14 **DR. DEHART:** But could they not then get the  
15 signature of a single employee --

16 **MR. KATZ:** Yes.

17 **DR. DEHART:** -- and serve then as an expert  
18 in that individual's --

19 **MR. KATZ:** Yes. And that's mentioned in the  
20 preamble, is that that may arise, that sort of  
21 situation.

22 **DR. ZIEMER:** Henry.

23 **DR. ANDERSON:** I guess one thing that we  
24 don't have is what the petition form and  
25 application will look like. And my question

1 would be is, depending on what that form looks  
2 like, it may be unreasonable to expect that an  
3 individual would have the wherewithal to complete  
4 that form.

5 So we're basically setting up a system  
6 whereby somebody has their individual case  
7 reviewed, and now they're sent back saying we  
8 can't reconstruct your dose; you may want to  
9 consider filing a petition for special cohort  
10 status. And is it reasonable that a next of kin  
11 or an individual would in fact have the hurdle  
12 low enough that they could in fact do that? Or  
13 would it be better in the rule to say you may be  
14 eligible, you should contact -- or set up some  
15 kind of a system for that person to be more of an  
16 active participant -- or passive participant than  
17 active?

18 It just seems to me it may -- it's tough  
19 enough for people to deal with the exposure  
20 issues of themselves. And until we know what's  
21 in that form, it may be totally unrealistic to  
22 send somebody something they can't possibly do,  
23 or they would have to hire and spend considerable  
24 money to hire somebody to do it on their behalf.

25 **DR. ZIEMER:** The content of the petition is

1 set forth --

2 **DR. ANDERSON:** Is it?

3 **DR. ZIEMER:** -- in 83.9.

4 But Ted, perhaps you --

5 **MR. KATZ:** I just was going to -- that's  
6 true. It's sort of the -- the framework is laid  
7 out there. The petitioner form will be more  
8 useful than that framework for petitioners. But  
9 in the case that you were mentioning of someone  
10 for whom we haven't been able to do dose  
11 reconstruction, a survivor, they basically don't  
12 have to -- there is no hurdle for them, other  
13 than giving sort of identifying information and  
14 the finding that we couldn't do a dose  
15 reconstruction. There is no other burden on them  
16 in terms of making the petition go forward to be  
17 accepted by HHS for evaluation.

18 **DR. ANDERSON:** Okay, because I thought the --  
19 it would go forward, and then what would be your  
20 evaluation? If all they have to do is turn  
21 around and say here's why I think it may be, what  
22 does your evaluation do but rely on what they  
23 submit, I guess, is the question.

24 **MR. KATZ:** So our evaluation fleshes out how  
25 many other employees fit their circumstances and

1 would comprise the class that they represent,  
2 that being a class of individuals for whom, in  
3 the first place, dose reconstructions can't be  
4 done. So that would be the first step. And the  
5 second issue is whether they incurred a dose that  
6 could cause specified cancers. But this is all  
7 done by NIOSH, not by the petitioner.

8 **DR. ANDERSON:** So if you then went back  
9 through the list that's been reviewed and found  
10 somebody who you could do a dose reconstruction  
11 on, say it's somebody with a prostate cancer, and  
12 then their claim is denied, how would that go  
13 into the class --

14 **MR. KATZ:** In this case we just found that we  
15 couldn't do a dose reconstruction for the  
16 individual, so we would have -- again, we would  
17 have looked at co-workers of this individual as  
18 well.

19 **DR. ANDERSON:** So you may be looking at  
20 classes --

21 **MR. KATZ:** In making that original  
22 determination that we can't do a dose  
23 reconstruction, one of the avenues that you will  
24 search when you do that is if we don't have data  
25 to reconstruct the dose for this individual, do

1 we have it to reconstruct it for other  
2 individuals who were similarly exposed? So --

3 **DR. ANDERSON:** So you would have determined  
4 -- I guess my concern, I don't see how you get to  
5 a class if you've done it on -- if you look to  
6 see does this person belong to a class --  
7 everybody's going to belong to some kind of a  
8 class. So you're going to say, okay, how -- see  
9 what I'm saying?

10 **MR. KATZ:** Our job is to define that class.  
11 When an individual is denied because we couldn't  
12 do a dose reconstruction, at that point we will  
13 have done considerable work looking at co-workers  
14 and so on and know a considerable amount about  
15 the situation, not just the individual's case.  
16 But we have to go on from there and define the  
17 parameters of that class beyond that individual  
18 as a first step, and that would be a class of  
19 individuals for whom dose reconstruction can't be  
20 done. And then there's the second question as to  
21 whether they were exposed at a level that would -  
22 - that could cause specified cancers.

23 **MR. PRESLEY:** I may open a can of worms --  
24 Bob Presley. Can we, as a Board, look at a group  
25 of people and make a recommendation that they be

1 added to the special cohort?

2 **MR. KATZ:** Not under this rule, no. You  
3 can't independently, in other words, identify a  
4 class of employees.

5 Let me just clarify, first of all. You are  
6 empowered to make recommendations to the  
7 Secretary of HHS on everything that's covered in  
8 your charter. But in terms of the procedures for  
9 the Special Exposure Cohort, under the proposal  
10 your recommendations come in after NIOSH has  
11 already done an initial evaluation of a petition.

12 **DR. ZIEMER:** Tony.

13 **DR. ANDRADE:** It seems like even after the  
14 presentation this morning, which I tried to  
15 parallel process as I was once again going  
16 through the *Federal Register*, the proposed  
17 legislation -- let's not forget that -- but even  
18 after that, I found myself very ill at ease with  
19 what has been written into the proposed  
20 legislation. It certainly did not have the  
21 clarity nor the specificity with which -- or  
22 which was included in your presentation. It does  
23 not say, for example, that one might be  
24 considered for a Special Exposure Cohort if there  
25 is new documentation, there is new information

1 about an individual or a group of individuals  
2 brought to light. That should be in here. That  
3 should be clarified. That is the comment I have  
4 about what's in the *Federal Register*.

5 Number two is that I find the table of using,  
6 say, leukemia versus solid tumor and then latent  
7 periods as a comparison for finding the lowest  
8 dose rather arbitrary, especially given a case in  
9 which perhaps a dose reconstruction couldn't be  
10 done because there was a huge uncertainty or  
11 perhaps not even any very good knowledge about  
12 doses involved at all. So I find that arbitrary,  
13 period. And it's very -- and it's disturbing,  
14 again, that we're not using science but rather  
15 something that's contrived to try to go forth  
16 with setting a level at which one would consider  
17 putting together a Special Exposure Cohort.

18 I would say that I think the probability is  
19 going to be very small that we do run into  
20 situations in which we're going to have a group  
21 of workers that we just know so very little about  
22 that we're going to have to define one. However,  
23 let's say one does exist or a couple do exist.  
24 Then let's make this legislation very clear that  
25 one can go forth with a proposal, but there has

1 to be a commonality of lack of data or lack of  
2 understanding of data for this group of people  
3 from, I would suppose, a site, a site where it  
4 would be most common that you would have a group  
5 of people for which -- that were doing some kind  
6 of work that no records were kept for, something  
7 happened along the way, and that reconstruction  
8 became an impossibility. It just has to be  
9 clearer in the proposed legislation as to what  
10 those trip points are going to be.

11 I think you did a good job in your  
12 presentation. I think the *Register* should  
13 reflect it.

14 **DR. ZIEMER:** Jim, just one moment.

15 The question was raised earlier about what  
16 this Board can do with respect to special  
17 cohorts. The charter says:

18 (Reading) upon request by the Secretary,  
19 advise the Secretary on whether there is a class  
20 of employees at any DOE facility who were exposed  
21 to radiation, but for whom it is not feasible to  
22 estimate the radiation dose or whether there is  
23 reasonable likelihood that such radiation doses  
24 may have endangered the health of members of the  
25 class.

1           It does not appear to restrict the Board as  
2 to how they go about establishing that, whether  
3 it be through this proposed rule-making or  
4 outside the rule-making. I don't see, at least  
5 in the charter, that it necessarily restricts the  
6 Board on that issue. Just an observation.

7           Jim, did you raise your hand?

8           **DR. MELIUS:** Make sure we have on our list --  
9 I think they both have been mentioned  
10 specifically, but in terms of specific parts of  
11 it -- that one of the issues we should discuss,  
12 and the Board may want to comment on, is how  
13 classes of employees will be determined for the  
14 purposes of the Special Exposure Cohort. And  
15 secondly, is this endangerment criteria that Tony  
16 was just really talking about, both that issue  
17 with the latency, type of tumor, et cetera, as  
18 well as the general approach for that.

19           **DR. ZIEMER:** Others?

20           Yes, Henry.

21           **DR. ANDERSON:** Yeah, I want to just raise  
22 again the issue of how do we, if we want to,  
23 comment on should it be a rule, should it be an  
24 interim rule, should it be guidelines. And I  
25 think we heard that because it seemed to be or

1 NIOSH felt it was prescriptive, it therefore made  
2 more sense than a rule. And what I've gathered  
3 is there's enough kind of uncertainty in how this  
4 will be applied that it would seem to me it may  
5 well fit better guidelines.

6 If the idea is to hold the Agency accountable  
7 it seems to me there's enough uncertainty in how  
8 the process is going to be applied that it's  
9 going to be a best judgment, many situations  
10 defended with the justification behind it, that  
11 unlike the other, it -- I'm not sure it really is  
12 -- that we gain anything by having it be a rule  
13 versus the others. And I guess I'd like to hear  
14 more about why you feel this fits better with a  
15 rule than a guideline for how one approaches  
16 this, when it seems to me there's a fair amount  
17 of inner-decision logic rather than science in  
18 your process that you're proposing.

19 **MR. KATZ:** Sure, let me -- this is Ted Katz  
20 again. Just to clarify, this was not NIOSH  
21 wanting to produce a rule versus guidelines.  
22 That's not what this is about. This is lawyers  
23 and the government looking at this and saying  
24 based on legal precedent this needs to be a rule.  
25 And I think you'll actually -- it wouldn't be a

1 good use of your time to be arguing that this  
2 should be guidelines instead of a rule, because  
3 it's being made on the basis of law and not on  
4 the basis of a preference, I should say. And as  
5 you know, HHS actually preferred to produce  
6 guidelines and found itself with difficulty,  
7 finding that in fact it needed to produce this as  
8 a rule.

9 **DR. MELIUS:** Could we take maybe five minutes  
10 and have an HHS lawyer explain that to us? Since  
11 they're all the way here in Denver --

12 **MR. KATZ:** There's really no more for them to  
13 tell you than what I've told you, which is  
14 specifically that there is case precedent that  
15 when you have a certain degree of specificity in  
16 requirements, in effect, when you have  
17 requirements that are binding on an Agency, that  
18 in effect operates like a regulation, and hence  
19 is supposed to be a regulation, and in fact can  
20 result in then a challenge if it's not issued as  
21 a regulation. So it needs to be issued as a  
22 regulation, and just -- the lawyers from HHS  
23 looked at this issue. Lawyers from the *Federal*  
24 *Register* looked at this issue. This was a well-  
25 vetted issue that they came to this conclusion

1 on.

2 **DR. ZIEMER:** Ted, is it also the case that by  
3 going through rule-making you also assure the  
4 public process that might otherwise be bypassed  
5 with a guideline, or not?

6 **MR. KATZ:** Well, it's absolutely true.  
7 You're not bound by the Administrative Procedure  
8 Act if you don't produce a regulation. You're  
9 not bound by that. You don't have to have public  
10 notice and comment and so on.

11 In reality, with our guidelines we were  
12 always planning to have public notice and  
13 comment, so we were almost -- we were doing  
14 almost all of what it would require to have a  
15 regulation anyway. And in a sense, this is a  
16 formality that it was decided that it would then  
17 be produced as a regulation instead of as  
18 voluntary guidelines.

19 **DR. ZIEMER:** It would appear to me also that  
20 even though there's right now in our minds a  
21 great deal of uncertainty, in fact the Agency  
22 would like there to be more specificity so that  
23 we do know, going in, what the rules of  
24 engagement are for this approach.

25 Tony, you have a comment?

1           **DR. ANDRADE:** Yeah, one more comment. Again,  
2 I truly believe that this is going to be used  
3 less often than not. But nevertheless, I had no  
4 objection to it being turned into or codified.

5           However, I really believe that the criteria,  
6 the criteria or guidelines, if you will, that are  
7 entered into the Code itself have to be extremely  
8 clear. And I think that one of the criteria that  
9 I'm feeling is bothering us here is that -- or  
10 criteria that does not exist and is bothering us  
11 here -- is that we don't want this to be an  
12 automatic third step in the petitioning process.  
13 We want this to kick in if there are very clear  
14 guidelines: Lack of information, a group of  
15 individuals for whom that lack of information is  
16 common, perhaps site commonality, perhaps work of  
17 those individuals, et cetera, et cetera.

18           I think that the proposed rule, as it is  
19 written, is incomplete. It leaves us with a bad  
20 flavor, and I just don't think it's anywhere near  
21 ready for finalization without, I think, some  
22 extensive mark-up that can come from this  
23 committee, from this Board. And I know that this  
24 Board is free to do so, at least to make  
25 recommendations.

1           **DR. ZIEMER:** Thank you.

2           I have a question, and maybe, Ted, I'll  
3 direct it to you again. I notice that in Section  
4 83.14 it says as a matter of -- item (e):

5           (Reading) As a matter of discretion, the  
6 Secretary may consider other factors or employ  
7 other procedures not set forth in this part when  
8 he deems necessary to do so to address the  
9 circumstances in a particular petition.

10           It seems to me that that opens the door for  
11 almost anything to override what's already in the  
12 rest of the rule. Could you help me understand -  
13 - and that same sort of thing is repeated near  
14 the very end. It's 83.16, item (3),  
15 recommendation by the Board to the Secretary as  
16 to whether or not Secretary should cancel or  
17 modify, and so on. It says any -- or it's  
18 actually number four:

19           (Reading) Any additional procedure the  
20 Secretary may deem appropriate, as specified in  
21 the notification.

22           I realize the Secretary needs some latitude  
23 and discretion in making the decision, but it  
24 looks like all kinds of other factors could be  
25 brought in. As a minimum I would think that we'd

1 have to say any other procedure that does not  
2 conflict with the established procedures, because  
3 otherwise you can override everything. I'm  
4 having a little trouble understanding the intent  
5 there. I know it's sort of a catch-all, if all  
6 else fails let the Secretary make the decision or  
7 something. But --

8 **MR. KATZ:** Well, in fact it is an open, vague  
9 opportunity for discussion on the part of the  
10 Secretary, and it is there because of not being -  
11 - because of the situation we have, which is we  
12 have considerable -- I can't use the word  
13 uncertainty, but I don't know which term to use -  
14 - about exactly how things will work down the  
15 road. And this was simply a parameter left in  
16 there for the Secretary in case there are  
17 situations we don't envision that require other  
18 procedures.

19 Should such measures be taken, it certainly  
20 would be taken in full public view and with the  
21 involvement of the Board, but there's not more to  
22 explain about it. That's exactly what it is.  
23 It's an open door, and it was put there with the  
24 intention of having unknowns out there in terms  
25 of how this world is going to evolve in terms of

1 Special Exposure Cohort petitions, what those  
2 circumstances are going to be.

3 **DR. ZIEMER:** Okay. Other comments?

4 (No responses)

5 **DR. ZIEMER:** I call attention to the fact  
6 that in the document probably the first almost  
7 half or more -- I didn't count up pages -- but  
8 the actual rule-making itself is probably less  
9 than half of the document. It's sort of -- for  
10 general purposes I'll call it the last half. I  
11 think it's a little less than that. The first  
12 section is really sort of background information  
13 and discussion of why they're doing the document  
14 and so on. The rule-making itself is the rest of  
15 this, this back half.

16 And let me ask, because I've asked this  
17 specific question, are there specific things in  
18 the body of the rule itself that you would like  
19 clarified at the moment before we go any further?  
20 Do you have questions on the meaning or something  
21 like that?

22 **DR. ANDERSON:** Paul?

23 **DR. ZIEMER:** Yes, Henry.

24 **DR. ANDERSON:** We can go through some of this  
25 now, but I'm just wondering, since there does

1            seem in this case to be some time and we haven't  
2            had a lot of time to review this, if there's  
3            going to be public meetings for additional input.  
4            It would seem to me before we finalize something  
5            it would be nice to hear what those other  
6            comments are.

7                       So I'm wondering if there is going to be  
8            these meetings, whether we might want to have a  
9            subgroup that might work along the lines that you  
10           were saying, to try to -- we could even break up  
11           into a workgroup tomorrow or something to try to  
12           start drafting something, that we could then come  
13           back together at our next meeting, hopefully  
14           either in conjunction with one of the public  
15           comment -- say the last comment session or right  
16           after that to finalize our comments, rather than  
17           draft comments, send them in now, and then  
18           potentially have other comments that we haven't  
19           thought of that workers would bring at the public  
20           meetings.

21                      So I don't know when our next meeting or what  
22           -- I would only want to do it here if it's  
23           impossible for us to get together for discussion  
24           of suggested comments. I think we've had a fair  
25           amount of uncertainty feeling here. Translating

1 that into specific language, I think, is somewhat  
2 difficult.

3 **DR. ZIEMER:** Well, there basically are almost  
4 two month till the comment deadline.

5 **DR. ANDERSON:** Yeah.

6 **DR. ZIEMER:** I think the target that we heard  
7 was that these public things would be in the next  
8 six or seven weeks, the last one of which would  
9 occur maybe a couple of weeks before the August  
10 26th deadline. How --

11 **DR. ANDERSON:** But I'd like to hear what --

12 **DR. ZIEMER:** What is the process for  
13 compiling that information and promulgating it?  
14 Is that done in a sort of a timely fashion? In  
15 other words, how easily would it -- how easily  
16 could the Board have access to the Q and A stuff  
17 that comes out of that meeting, those meetings?

18 **MR. KATZ:** So the public comments, I'm sure  
19 we will handle it as we did in the past. We will  
20 put those public comments in our docket. It's  
21 going to be open on the web, as it was with the  
22 other two rules, and you'll have access to those  
23 public comments, written comments that are  
24 submitted that way.

25 In terms of the comments that are made at the

1 four town hall meetings, all those meetings will  
2 be recorded, and that material will all be put on  
3 the docket, too. And in the process going  
4 forward we will want the Board's recommendations  
5 before we -- obviously before we finish our work.  
6 But the process is to consider all those  
7 comments, address them all, and -- are you asking  
8 about our questions and answers in response to  
9 those, seeing those? Or are you asking for --

10 **DR. ZIEMER:** Well, as a minimum, what the  
11 questions are and the comments that are presented  
12 in the public meeting, I think is what Henry was  
13 referring to.

14 **DR. ANDERSON:** Yeah, it gives us some  
15 additional input. We may say, well, that isn't  
16 relevant, but at least we will have had an  
17 opportunity to consider, though.

18 We were the last commenters, I would say, on  
19 the first two rules. So now we have it fairly  
20 early on, we've got some time. Let's be near the  
21 end again so we can hear those. The written  
22 public comments, if they come in in time for us  
23 to look at them, fine. But their deadline's  
24 going to be the same as ours, so they may not  
25 come in in a timely fashion for us to read them;

1 where the town meetings, those you could be able  
2 to capture what the sense -- are they all over  
3 the map, are they different in different regions?  
4 And that might help us in then taking individual  
5 comments to focus them into a Board set of  
6 comments as well.

7 That's my only suggestion, that if that could  
8 be done, that would seem to me to be -- at least  
9 to me it would be helpful to hear. I don't know  
10 enough about the nuances of a lot of this that  
11 I'm sure people who are out there in the field or  
12 workers are perhaps going to have a better handle  
13 on, and get a sense of how -- how many of these  
14 are there going to be? If it's 90, is it -- what  
15 that means for the Board. We'll get a better  
16 sense from the public comments, I think. Or  
17 maybe, I'm hoping.

18 **DR. ZIEMER:** Ted, that 90 number, in your  
19 mind what did that represent? Ninety individuals  
20 or 90 groups?

21 **MR. KATZ:** That was 90 petitions, but the  
22 vast majority being generated as a result of us  
23 not being able to complete dose reconstructions;  
24 so the vast majority being generated as a result  
25 of us not being able to do individual dose

1 reconstructions coming from individuals.

2 **DR. ZIEMER:** But a number of those could  
3 commonly -- or be common to one site or location  
4 where --

5 **MR. KATZ:** That's possible, right.

6 **DR. ANDERSON:** The difficulty is it will  
7 become much more robust as you get more and more  
8 submissions. The first person or the first ten  
9 people who you can't do their dose reconstruction  
10 and you look for are there others like them out  
11 there, you aren't going to know because there  
12 aren't any others that have been submitted that  
13 have been turned down yet or have not been  
14 reconstructed. So you're more then into more  
15 speculative -- well, there may be a lot of these  
16 people out there, but we don't know.

17 And so it's kind of how robust does it have  
18 to be, or will you look at it and say, well, this  
19 one individual seems to have -- potentially meet  
20 some of your criteria, though you can't do the  
21 dose reconstruction. So you might -- would you  
22 see recommending certifying a single individual  
23 and then wait to see if there's others in the  
24 class that come up? I just have a hard time that  
25 as the -- when you first look there's nobody else

1           like them there, so would they possibly get  
2           turned down as a class because we can't identify  
3           a class?

4           **MR. KATZ:** We don't think there will be -- we  
5           think that would be an extremely rare  
6           circumstance where there is an individual whose  
7           situation is unique, and hence would comprise a  
8           class alone. So we're really thinking with these  
9           individual dose reconstructions, again, that  
10          those are a sentinel for an entire class that has  
11          yet to be recognized.

12          So it's not a matter of 90 individuals in 90  
13          separate classes, but really when the individuals  
14          come forward and we can't do a dose  
15          reconstruction, then it's a question of how many  
16          individuals are in the boat with them and  
17          defining that class. And it probably will, in  
18          effect, short-circuit the concern I think that  
19          you could have that, well, you'll get a lot of  
20          individual requests from one site, and you won't  
21          be able to do each of them; but once you fail on  
22          one, the word's going to go -- the person can  
23          petition, and then you'll start looking at who's  
24          in the boat with them. And if there are other  
25          individual dose reconstructions in the pipeline

1 you would still carry forward on them, but as  
2 soon as it became clear that they're part of that  
3 class you'd be cutting to the chase there and  
4 defining your class.

5 **DR. ANDERSON:** If it's just when do you close  
6 it out -- the data will -- as you continue to  
7 review, some may come in, and --

8 **MR. KATZ:** Well, it's not reviewing on an  
9 individual basis. It's going back based on an  
10 individual not having a dose reconstruction.  
11 It's looking at the data that speaks to all the  
12 workers in that individual situation. So it's  
13 not sort of boundless, I think -- I'm not sure I  
14 understand you -- but it's not boundless at all.  
15 It's determining, well, how -- what's the scope  
16 of this class.

17 **DR. MELIUS:** How much work -- what's the  
18 workload involved and timetable involved in  
19 looking at those 90 petitions?

20 **MR. KATZ:** What's the workload involved in --

21 **DR. MELIUS:** How long is it going to take to  
22 complete the average evaluation for a class  
23 petition?

24 **MR. KATZ:** I can't recall what we estimated  
25 in terms of hours of work to address one of those

1 petitions.

2 **DR. MELIUS:** Or time, do you have no --

3 **MR. KATZ:** No, it wasn't -- we didn't have to  
4 address it in terms of a time line. We would  
5 have addressed it in terms of hours of work, but  
6 I don't -- I just don't recall. I couldn't tell  
7 you, off the top of my head, what sort of labor  
8 we had guessed at in terms of addressing one of  
9 those petitions.

10 **DR. DEHART:** I've read an awfully lot in the  
11 last couple of weeks on this topic, and I may be  
12 confused as to where this sits, but wasn't a  
13 provision made for an individual who would not  
14 qualify as a claimant because there is no cancer,  
15 but would qualify to enter as a petitioner to  
16 this program because he may have cancer?

17 **MR. KATZ:** That's exactly right, and that's  
18 why --

19 **DR. DEHART:** So that opens it up to every  
20 employee, basically, who has been an atomic  
21 worker?

22 **MR. KATZ:** That's exactly right. It is not  
23 limited to -- you do not have to have incurred a  
24 cancer to petition to be part of the cohort.

25 **DR. ZIEMER:** But you do have to have the

1 cancer to get the --

2 **MR. KATZ:** To get compensated.

3 **DR. ZIEMER:** -- compensation, yes,  
4 eventually, right.

5 **DR. MELIUS:** And if you don't -- if you don't  
6 have the cancer, you're not a claimant, you  
7 haven't been turned down, you have to meet a  
8 higher level of proof in your application. Your  
9 petition has to -- excuse me, your petition has  
10 to meet a higher degree of --

11 **MR. KATZ:** Really, to clarify, it's not a  
12 higher -- in a sense, the person who's had a dose  
13 reconstruction turned down has met a higher  
14 burden of proof, but -- and probably will have  
15 put more labor into it, being involved with us in  
16 the dose reconstructions, but in any event there  
17 are requirements. There is sort of a threshold  
18 of effort they have to put in to petition, that's  
19 true.

20 **DR. ZIEMER:** Jim has a comment.

21 **DR. NETON:** I just sense that there may be  
22 some confusion; maybe it's just me. But when the  
23 SEC petition is evaluated, we're evaluating not  
24 individual workers but a particular work  
25 activity. So you don't qualify like 20

1 individuals and say those 20 individuals are in  
2 this class. There's a particular work function  
3 that may have occurred.

4 And I'm reluctant to give examples, but  
5 someone working in a facility changing out some  
6 kind of filtration mechanism or something, there  
7 was no monitoring but we recognize that that  
8 filtration mechanism had a large potential amount  
9 of some actinide material that is -- since  
10 there's no urinalysis, no TLD information, we  
11 can't put any estimate on that exposure at all,  
12 but we recognize that it is potentially  
13 sufficient to have caused cancer in that class of  
14 workers.

15 But once that class is established, then  
16 anyone who did that particular function is  
17 eligible to apply for that class. And we would  
18 evaluate them at that time -- did they really  
19 work during the constraints of the time frame  
20 that we specified and at that particular  
21 facility, those type of criteria. So it's not  
22 really qualifying an individual. It's a group of  
23 -- a work function, essentially, or even a whole  
24 facility, as Tony had mentioned.

25 **MR. KATZ:** I'm sorry, it's Ted again. But

1 just to clarify for the record, that evaluation,  
2 then, once the class is established, the  
3 Department of Labor is responsible for saying do  
4 you fit in this class. So they are the ones who  
5 make that judgment, not HHS.

6 **DR. ANDRADE:** No, I don't think that there's  
7 any misunderstanding about that here around the  
8 table. As a matter of fact, if what you said was  
9 written into the *Register*, I think the point  
10 would be moot. We're looking for commonality to  
11 establish a cohort. We cannot do this for  
12 individuals. And that commonality can be just  
13 about any sort of thing.

14 **DR. NETON:** I don't think that it's possible  
15 to define those particular job functions. I hope  
16 that's not what you're suggesting.

17 **DR. ZIEMER:** No. No, no.

18 **DR. ANDRADE:** No, I'm saying commonality.

19 **DR. NETON:** Commonality.

20 **DR. ZIEMER:** And that perhaps would go a long  
21 way to clarifying the intent here.

22 **UNIDENTIFIED:** Exactly.

23 **DR. MELIUS:** And I think if that were carried  
24 over to the question of the individual  
25 application, because it's really going to be some

1 of those same criteria, whatever we want to call  
2 them, that would apply to a group and define a  
3 class in terms of what information's available  
4 and so forth that would apply in an individual  
5 case, which is why you couldn't complete their  
6 dose reconstruction. And it would seem to me  
7 that if NIOSH is not capable or doesn't want to,  
8 whatever -- I don't understand -- come up with  
9 these criteria, that one of the recommendations  
10 that the Board should make is either those  
11 criteria be developed or that we develop some  
12 criteria ourselves as recommendations. In fact,  
13 I think in order to deal with the issue of  
14 reviewing dose reconstructions we're going to  
15 have to wrestle with that issue at some point  
16 anyway as a Board.

17 **DR. ZIEMER:** Some of these individual ones,  
18 it appears -- and I think the word you used, Ted,  
19 was they're sort of sentinels -- they trigger you  
20 to begin thinking, is there this class of  
21 individuals for whom this person perhaps is a  
22 surrogate or a representative? And it may be  
23 that that point simply is not clearly stated  
24 here.

25 **DR. ANDERSON:** I think what's more clear when

1 you say a specific activity, that's different  
2 when you say acting as a sentinel. To me, when  
3 you say sentinel, that's the whole person, and it  
4 would be his lifetime exposure and all as opposed  
5 to an incident, event, or a period of -- a three-  
6 year period of time when everything was lost or  
7 whatever. I think that kind of detail probably  
8 needs to be in there.

9 **DR. ZIEMER:** Possibly could be either.

10 **DR. ANDERSON:** But rather than if you can't  
11 do a dose reconstruction, you're really saying  
12 the person's whole lifetime of employment you  
13 couldn't do a dose reconstruction, or are you  
14 just saying this component in your dose  
15 reconstruction we can't do? That, to me, isn't  
16 clear. It seemed to me that denial is to get  
17 back to the person, say we can't reconstruct your  
18 dose, not your dose in 1953 or your dose in  
19 February of '64. It's rather we can't do your  
20 dose reconstruction for your period of  
21 employment. And that, I think, is the confusion  
22 here. At least to me --

23 **DR. ZIEMER:** Well, maybe --

24 **DR. ANDERSON:** -- if you're maybe looking at  
25 a specific segment of time where you say we --

1 there's a critical period in your work history  
2 where we have no exposure information; therefore,  
3 we can't do a reconstruction.

4 **DR. ZIEMER:** Could you clarify that, Ted,  
5 because it may very well be that you can  
6 reconstruct everything except what occurred with  
7 regard to a particular incident.

8 Is that what you're -

9 **DR. ANDERSON:** Yeah.

10 **MR. KATZ:** We've talked about that. I talked  
11 about that in my presentation, too. It's  
12 absolutely true. We're not concerned with the  
13 periods when we can reconstruct the dose. We're  
14 concerned, in effect, with is there a period when  
15 you can't reconstruct a dose? That's sufficient.  
16 It doesn't have to -- they can have perfect  
17 records for three-quarters of their career.  
18 What's important is a period for which there  
19 aren't records or adequate records. So that's  
20 the issue.

21 But I want to clarify also what Jim was  
22 saying with activity. Activity -- and you, then,  
23 in effect, Dr. Anderson, you started to rattle  
24 off the reason why we're saying we can't be more  
25 specific. Jim said that an activity, for

1 example, and he gave you this example. Well,  
2 that is just one example of a situation where  
3 you'd have basis for a cohort. But there are  
4 other situations, too. They could be in the same  
5 area doing completely different tasks, and have  
6 incurred radiation doses that can't be measured.  
7 So that's not it. That's just an example that  
8 Jim was giving of a circumstance.

9 **DR. ZIEMER:** Wanda.

10 **MS. MUNN:** Thank you.

11 I'm wondering if we're kind of getting out in  
12 front of ourselves here and trying to do what  
13 many of our jobs have taught us to do, which is  
14 look at the minutiae instead of the big picture.  
15 Because I have a hard time seeing that there is  
16 likely to fall upon this Board any large amount  
17 of material that is not already covered in what's  
18 here, perhaps with some additional specifics, as  
19 Tony has indicated.

20 But on page 50 there is -- of the material  
21 that we have here -- there is a table identifying  
22 what the petitioner needs to identify or not  
23 identify in terms of becoming a special cohort.  
24 And almost everything that I've heard talked  
25 about around this table involves some class or

1 some incident that is either specified or  
2 referred to here on this table.

3 Further, anything that we would see would  
4 already have gone through this process, and as I  
5 read page 51, would come to us for review  
6 primarily of what the Secretary's decision was,  
7 not as to what the contents of the file were. Am  
8 I incorrect in that? I believe what I'm reading  
9 here is there's a very defined process. If the  
10 Secretary does not find that this petition meets  
11 the requirements, then and only then would this  
12 Board become involved. And the Board, as I read  
13 this, will have an opportunity to review the  
14 Secretary's recommendation as to why that finding  
15 was made. And really that's all we're being  
16 asked to do, I think.

17 Am I incorrect, Ted?

18 **MR. KATZ:** Yeah, you are.

19 **MS. MUNN:** I'm wrong. Okay.

20 **MR. KATZ:** I'm sorry. But there are two  
21 phases, in effect.

22 There's the first phase, which is deciding  
23 whether HHS is going to evaluate the petition in  
24 full, and that's what I think you're talking  
25 about there. There the Board would only make

1 recommendations if we were saying -- HHS were  
2 saying this petition doesn't warrant being  
3 evaluated. In that case, it would come before  
4 you before it was decided not to evaluate that  
5 petition, and you would in effect be sort of a  
6 review element of that decision, and you would  
7 make recommendations to us as to whether or not  
8 we should in fact be evaluating that petition.  
9 So I think that's what you're addressing on those  
10 pages.

11 But you are fully involved as a Board, once  
12 we evaluate a petition, in overseeing our  
13 evaluation and making recommendations to us with  
14 respect to our evaluation.

15 **DR. ZIEMER:** Sally.

16 **MS. GADOLA:** Ted, this sort of gets back to  
17 what I first was talking about, and I just wanted  
18 to ask you the question and it's to clarify it in  
19 my own mind. And I liked your illustration when  
20 you were talking about putting people in a boat.  
21 I am assuming that with the IREP that there is a  
22 way that you can capture some of this information  
23 that shows that you're not able to do the dose  
24 reconstruction, but there are some similarities  
25 that would put these employees in a boat. Are

1           there?

2           **MR. KATZ:** Yes. This is -- again, this not  
3 IREP, but our task will be to lay out very  
4 clearly which individuals we can't do dose  
5 reconstruction for and why. So the parameters of  
6 the class -- in the case of doing a dose  
7 reconstruction you have to lay it out very  
8 clearly for that case, that dose reconstruction.  
9 When you go on to a Special Exposure Cohort  
10 petition, we're going to have to lay out very  
11 clearly what information exists, what doesn't,  
12 and why that prevents us from being able to do a  
13 dose reconstruction. And that would then come  
14 before you, that whole logic, the data behind it  
15 and so on, for your evaluation.

16           **MS. GADOLA:** Thank you. I think that's why I  
17 was first saying I assumed that NIOSH would be  
18 the first ones to often recognize this group,  
19 which I would call a cohort rather than  
20 individuals, being able to say, well, I'm sure  
21 that this must have happened at work because I  
22 remember so-and-so, but I don't have -- I just  
23 wanted to hear you reiterate how that is possible  
24 to capture some of this data.

25           And I think all of that helps us to clarify

1           whether or not there really are going to be  
2           individuals to put in the boat, because some  
3           people think, well, it'll just be a very, very  
4           few, and that might be true. But you need some  
5           type of data to go by and some type of standards  
6           to go by. And if you have two or three people at  
7           Oak Ridge and two people in Paducah and so forth,  
8           how are they going to know about each other?

9           **MR. KATZ:** Well, let me just -- that's an  
10          important point to clarify. The petitioners have  
11          to be actually from the same facility to be in  
12          the same class, to be in a single class. So you  
13          can have separate classes that can have very  
14          similar circumstances at different facilities,  
15          but they would be separate petitions.

16          **MS. GADOLA:** Okay. So one of the ways that  
17          they get in the boat is if they worked at the  
18          same site. What I was thinking was if they did -  
19          - also if they did the same type of job at  
20          different sites, but that could vary what they  
21          were exposed to by a large amount of radiation  
22          dose.

23          **MR. KATZ:** And as the Board was discussing  
24          earlier, I think Dr. Ziemer was saying that  
25          practices were fairly different at different

1 sites, too. So at one site you may have had good  
2 record-keeping, good information available, and  
3 another site not, too.

4 **MS. GADOLA:** Okay. And that sort of goes  
5 back to my first comment, too, is about the way  
6 that the first cohorts were established by  
7 Congress was according to where they worked. It  
8 was site-specific.

9 **MR. KATZ:** That's correct.

10 **MS. GADOLA:** And that's something that we  
11 might be seeing in the future, that certain  
12 sites, certain departments may end up being a  
13 special cohort.

14 **MR. KATZ:** Or parts of a site, not  
15 necessarily the whole site.

16 **MS. GADOLA:** It also seems like that would  
17 simplify things a lot for everyone, once that was  
18 established. Thank you.

19 **DR. ZIEMER:** Ted, does the -- maybe I missed  
20 that. I think that's a point that perhaps is  
21 worth stating somewhere -- maybe it is and I  
22 missed it -- that any special cohort will, as a  
23 starting point, have the commonality of site-  
24 specificity. Is that correct?

25 **MR. KATZ:** That's correct.

1           **DR. ZIEMER:** Is that stated?

2           **MR. KATZ:** It is stated.

3           **DR. ANDRADE:** It's 83.5 in subsection (c). I  
4 completely skipped over that myself. But that's  
5 what I mean about the clarity of the rule. If  
6 all of these --

7           **DR. ZIEMER:** I got it. I see it.

8           **DR. ANDRADE:** If all of these criteria were  
9 listed up front somewhere, where everybody  
10 understood precisely what needed to get -- what  
11 had to be done in order to be considered for an  
12 SEC, I think this would be a much more valuable  
13 document. It seems to be scattered throughout.

14           **MS. MUNN:** Maybe it would help to include the  
15 form, which I haven't pulled down and looked at.

16           **DR. ZIEMER:** I'm sorry, could you -- I missed  
17 that, Wanda. What are you saying?

18           **MS. MUNN:** I said it might even help to  
19 include the form, which is available on the home  
20 page, but I haven't pulled it down and looked at  
21 it -- the application form.

22           **DR. ZIEMER:** No, I don't think it exists yet,  
23 does it?

24           **MR. KATZ:** No, it doesn't exist yet. And  
25 that's written as it would be in a final rule,

1 where it would be available. But it's not there  
2 yet.

3 **DR. ZIEMER:** Incidentally, just as an aside,  
4 you'll notice in section 83.13 it talks about the  
5 consensus of this Board. And it has a footnote  
6 about that, so I think it's okay.

7 **DR. ANDERSON:** And if we wanted to be sure.  
8 If one person supports it.

9 **DR. ZIEMER:** No, we have -- it says it may --  
10 it's --

11 **DR. ANDERSON:** Yeah, it does not require you  
12 --

13 **DR. ZIEMER:** Right.  
14 Okay, additional comments?  
15 Yeah, Mark.

16 **MR. GRIFFON:** If we had a little time here,  
17 I'm just going on what Tony was talking about  
18 with the clear triggers. I completely agree.  
19 Part of my frustration with it was the lack of  
20 clear triggers.

21 And we've had discussions with NIOSH, and I  
22 guess what I wanted to explore maybe, if we had a  
23 few minutes now, was what was your thought  
24 process in defining things like reasonable  
25 estimate? It's defined as you can complete a

1           dose reconstruction. And I know that you turned  
2           it back and said, well, if you have a better way  
3           to do this, fine, give us a proposal. And I  
4           agree. I don't know that I have the perfect  
5           answer right now. But I can think of some  
6           quantitative -- potential quantitative triggers  
7           to be used to assist in determining that  
8           reasonable estimate idea. And I'm just wondering  
9           if it might be helpful to the Board if we heard  
10          some of -- I'm sure you went through a lot of the  
11          same thoughts that we're going through, on how  
12          can we possibly quantify this, and was there  
13          other -- can you share some of that logic with  
14          us?

15                 **MR. KATZ:** Well, we went through the issue of  
16                 -- because it was -- it's been mentioned before,  
17                 the issue of whether it's a question of the size  
18                 of the standard error, for example. Is that what  
19                 you're referring to, in effect, as a way of  
20                 clearly defining that? And the way we veered  
21                 from there or felt that was really inappropriate  
22                 is because the size of the standard error is not  
23                 harming the claimant in this case, as Dr. Ziemer  
24                 expressed over there when we were discussing this  
25                 provision before. If increased standard error

1 means more benefit of the doubt to the claimant,  
2 in effect, we're not harming the claimant that  
3 way, then that doesn't seem to us a good measure  
4 in this circumstance, which is, I grant it, it's  
5 sort of unique to what we've set up here in terms  
6 of how we're doing dose reconstructions. But it  
7 fits, I think, more or less like a glove with  
8 what we've proposed for doing dose  
9 reconstructions and what we're doing now there.

10 So again, our logic led us back to saying if  
11 we can do the dose reconstructions we are  
12 treating these claimants fairly. And our concern  
13 is about claimants who don't have this as a  
14 remedy, and those claimants are people for whom  
15 we can't do dose reconstructions. There's really  
16 -- there's no more logic to present to you than  
17 that, for whatever limits it has.

18 **DR. NETON:** I think I could just add a couple  
19 of things to that.

20 One thing I think is important is it's  
21 unbounded, reasonably unbounded at the upper end,  
22 where you can't necessarily put a handle on what  
23 the upper end of the dose of that cohort or that  
24 group or class of workers would be. Your other  
25 alternative would be to assign everyone some

1 extremely large exposure, which in effect  
2 qualifies them as a Special Exposure Cohort to  
3 begin with. That's the only alternative, is to  
4 say I know it's less than a million rem,  
5 something crazy like that.

6 And one could do that, but I think that's  
7 when you get into this reasonableness test.  
8 Well, that's probably not reasonable, but we  
9 don't really know. And that's part of that logic  
10 process, is this unbounded -- sufficiently high  
11 to have caused cancer, but unbounded at a very  
12 high end where you'd never be able to establish  
13 it with any certainty. All the other ones that  
14 we could do, we feel that we could bound it  
15 within some reasonable scientific certainty.  
16 There I go, use the word "reasonable" again.

17 But it's hard -- I'd be interested to hear  
18 whatever quantitative numbers you might have.

19 **MR. GRIFFON:** Well, yeah, I've been playing  
20 around with that, but it's not ready for sharing  
21 publicly yet.

22 But I guess the other concern I have, really,  
23 is from the standpoint of the potential  
24 claimants, that if we don't have some clear  
25 triggers, then I think there might be the

1 reaction that, oh, once again I just missed the  
2 hurdle; boy, surprise, surprise, my -- even on  
3 that maximum likelihood where you give them the  
4 worst case dose estimate, they may say, surprise,  
5 surprise, once again we missed the trigger for  
6 compensation. And I think that -- I guess I was  
7 just trying -- if there were clear triggers,  
8 clear triggers for you would be helpful, clear  
9 triggers for the Board when we reviewed things  
10 would be helpful, because we're going to have to  
11 put our opinion out on these things as well. And  
12 it would be helpful to the petitioners so they  
13 knew what they were up against, maybe.

14 And like I said, I don't have any clear  
15 answer to that. I'm just kind of exploring that.  
16 And that's my concern on that side, is that we're  
17 going to get a potential backlash of people that  
18 really believe their records were destroyed and  
19 information wasn't correct, and they go through  
20 this process again and -- your worst case  
21 scenario, they just don't believe that it was  
22 really a worst case scenario. So I think the  
23 review process is good, but I think the triggers  
24 would be helpful for everybody involved, is all  
25 I'm saying.

1           **DR. ZIEMER:** Mark, could you -- when you use  
2 the term "triggers" here, give me an example of a  
3 hypothetical trigger in your mind. What are you  
4 meaning by it?

5           **MR. GRIFFON:** I guess part of what I was  
6 talking about is how do you determine for the  
7 reasonable estimate. And it could be tied -- I  
8 think it could be tied to the uncertainty  
9 combined with the mean in a way that's end-  
10 cancer-specific, so that you look at your sigma  
11 values on either side and compare it against your  
12 IREP model and see what that does to probability  
13 of causation. And I don't know, maybe you've  
14 looked at this. I'm not saying -- that's just  
15 one notion of a --

16           **DR. ZIEMER:** Isn't that what you're doing, in  
17 essence?

18           **DR. NETON:** -- dose reconstruction.

19           **DR. ZIEMER:** You're doing a type of dose  
20 reconstruction in the absence of any data.  
21 You're saying this group might have gotten a dose  
22 this high, and that would --

23           **DR. NETON:** Right, that's exactly it. I  
24 don't want to get into too much --

25           **MR. GRIFFON:** Well, that's not quite how you

1 do a dose reconstruction. But like I said, I'm  
2 not really ready to put a model out there, but a  
3 dose reconstruction, you put the whole  
4 distribution into your calculations.

5 **DR. NETON:** Right. But these triggers are  
6 extremely -- if you run the IREP model, cancer-  
7 specific, age at exposure, it's specific to every  
8 individual, and I don't know that you could  
9 actually establish a single trigger value. It  
10 would not be possible, given the infinitely  
11 variable nature of the calculation, at least in  
12 my opinion.

13 **MR. KATZ:** Can I just --

14 **MR. GRIFFON:** I was proposing that more for  
15 the other side, with the individual where you  
16 want to determine if you can do a reasonable  
17 estimate. If that estimate is reasonable, then -  
18 - I'll leave it at that.

19 **MR. KATZ:** Well, I was just going to point  
20 out, too, that if you're -- but then I think he  
21 just canceled my comment in a sentence. If  
22 you're not talking about Special Exposure Cohort  
23 procedures, but where you apply this whatever  
24 kind of arbitrary or whatever trigger like this,  
25 the result of that is if it results in your

1 creating a class where you could have done dose  
2 reconstructions for those individuals, some of  
3 those individuals will have cancers that are not  
4 on the specified cancer list. And there you've  
5 basically taken away any remedy from them that --

6 **MR. GRIFFON:** I understand. I also think --  
7 and another -- I'm sorry, Wanda.

8 I think another definition that might play  
9 into this is -- and Ted did present on this a  
10 little today in the presentation -- was  
11 feasibility. And I think I disagree a little bit  
12 with Ted that the description, I think it can be  
13 defined to some extent, at least in terms of --  
14 we threw around examples of, well, you can always  
15 reconstruct a dose, given enough time and effort  
16 and -- but I think part of that plays into  
17 feasibility. How much time, effort, et cetera is  
18 going to be involved for one small class,  
19 possibly, to define a source term if you have to  
20 go back and characterize a dump site, for  
21 instance? I think that might be unfeasible, as  
22 an example. Maybe it's not. But I think that's  
23 something that might be able to be defined to  
24 some extent based on time and allocation of  
25 resources.

1           **DR. ZIEMER:** As a practical issue, if you  
2 have to spend \$50 million to decide whether 25  
3 people are a special cohort.

4           **MR. GRIFFON:** Yeah, right.

5           **DR. ZIEMER:** Wanda has a comment.

6           **MS. MUNN:** It's my observation that no matter  
7 what threshold of either dose or event is chosen,  
8 there will be people who didn't quite make that  
9 and who will continue to feel that they have been  
10 mistreated. I believe the only thing that people  
11 who are involved in this kind of activity can do  
12 is to do the best job they can based on the best  
13 science that's available to them, and not be  
14 swayed by the fact that there will be people who  
15 will be unhappy with whatever decision is made.  
16 You just have to use the best science that's  
17 available.

18           **DR. ZIEMER:** Thank you.

19           Okay, it's time for a break, unless there's  
20 -- does somebody have another comment?

21           **UNIDENTIFIED:** I think yeah was the comment  
22 over there.

23           (Laughter)

24           **DR. ZIEMER:** Okay, let's take a 15-minute  
25 break.

1 (Whereupon, a break was taken at 2:40 p.m.)

2 - - -

3 **DR. ZIEMER:** Our agenda actually calls for us  
4 to go back to dose reconstruction review process,  
5 but I think we agreed this morning, with the  
6 input to the working group -- and that group is  
7 going to meet sometime tonight, or after this  
8 session --

9 **MR. PRESLEY:** After this meeting.

10 **DR. ZIEMER:** So if it's agreeable, we'll defer  
11 discussion on dose reconstruction until tomorrow,  
12 then.

13 Mark, where are you? Is that agreeable? I  
14 guess it is. Mark, if that's not agreeable, say  
15 so.

16 (Mr. Griffon is not present.)

17 **DR. ZIEMER:** So let's go back to Special  
18 Exposure Cohort. We were kind of catching our  
19 breaths there, but you've had a chance to mull  
20 over things further. Do we have any additional  
21 comments at this time?

22 Oh, yeah, just a reminder to members of the  
23 public who wish to make comments to sign up.  
24 There are several already signed up, so we do  
25 have you on the schedule, at least three people

1 I'm aware of. Okay.

2 **MS. HOMER:** (inaudible)

3 **DR. ZIEMER:** Now up to four? Okay.

4 Okay, I've called for additional comments on  
5 the Special Exposure Cohort petitioning process,  
6 rule-making.

7 (No responses)

8 **DR. ZIEMER:** Do you feel like we've  
9 identified all the issues we need to address?  
10 There's a cross-section of them.

11 Okay, Roy.

12 **DR. DEHART:** You mentioned earlier the  
13 possibility of trying to have comments that could  
14 be placed on the docket for review. Is that  
15 still the intent, or as was suggested to let the  
16 course run its full outing and then put our  
17 comments in?

18 **DR. ZIEMER:** Well, I think it's up to this  
19 Board, number one, what it wishes to say and when  
20 it wishes to say it, so I'm not certainly  
21 dictating that. The comment period closes August  
22 25th or so, doesn't it?

23 **MR. ELLIOTT:** Yes.

24 **DR. ZIEMER:** And I think Henry suggested that  
25 we might wish to be made aware of the public

1           comments on this before finalizing anything that  
2           we do. Not that we are -- we certainly aren't  
3           going to do the staff's job, which is to respond  
4           to the public comments, but we would use those  
5           mainly to see if there are other issues that we  
6           think we should also be addressing, something  
7           that might be triggered by public input.

8           So Roy, and then Henry. Or Henry and then  
9           Roy.

10           **DR. ANDERSON:** Yeah, I was only thinking that  
11           as far as clarifying language or recommendations  
12           that we could make, there may be comments where  
13           the public is confused or has some questions that  
14           in fact, in honing in on our own comments, we  
15           could help address some of those.

16           **DR. ZIEMER:** Right. I would certainly  
17           suggest that we need to be pretty far along and  
18           maybe have a semi-final draft ready that we could  
19           say, okay, in light of the public comments, we  
20           might make some additional minor changes or  
21           massage it a bit. But we need to be ready to go  
22           by mid-August or so in any event.

23           **DR. ANDERSON:** Right.

24           **MR. ELLIOTT:** Just for clarity's sake, let me  
25           make sure everybody understands that when we

1 receive public comment on this notice of proposed  
2 rule-making, as soon as we receive that it'll be  
3 entered into the docket and available on the web  
4 site. That's a fairly innovative, very new  
5 practice in rule-making. We're the first to have  
6 done it with the two rules we've already  
7 completed. It's been our experience, though --  
8 and limited experience that it is -- that people  
9 wait till the last few days to provide their  
10 comments. And so I'd just caution you in that  
11 regard.

12 Secondly, with regard to the stakeholder  
13 meetings that we're proposing to conduct, we're  
14 going to attempt to get a transcript of those and  
15 put that on the web site as soon as it's  
16 available from the court recorder. So that would  
17 be to your avail as well.

18 **DR. ANDERSON:** It seems to me, though, that  
19 depending where you hold them it's likely to be  
20 that there'll be one Board member that actually  
21 may be in the town where your town meetings are  
22 being held, and we could maybe task that  
23 individual to go to the meeting to take some  
24 notes to give us that feedback. That was my only  
25 suggestion on it, is there may be something that

1 would be helpful that would help us make our  
2 comments more --

3 **DR. ZIEMER:** There will be a transcript, but  
4 probably you --

5 **DR. ANDERSON:** Yeah, that may be too late.

6 **DR. ZIEMER:** -- don't need the detailed  
7 transcript. You --

8 **DR. ANDERSON:** Yeah, and the published  
9 comments, I agree, I'm not --

10 **DR. ZIEMER:** You want more the flavor of the  
11 comments, and maybe a synopsis of what the issues  
12 were that were raised.

13 **DR. ANDERSON:** Right, right. And if those  
14 are ones that we could address, that would be  
15 helpful to NIOSH to have us do that, and then  
16 they can reference that.

17 **DR. ZIEMER:** Roy, did you have another  
18 comment? No. Gen.

19 **DR. ROESSLER:** What is the next planned  
20 meeting of the Board? I'm assuming that this  
21 discussion centers about maybe a teleconference  
22 if we had to get back together and make some  
23 decisions?

24 **DR. ZIEMER:** We don't actually have an  
25 additional meeting scheduled at this time.

1           That's one of the items of business before we  
2           leave, is to talk about the time for the next  
3           meeting. But if necessary, we can always have a  
4           teleconference. Keep in mind, though --  
5           teleconference, a telephone conference -- keep in  
6           mind, though, even that requires notice in the  
7           *Federal Register*, and it's not a minor matter.

8           **DR. ROESSLER:** So how would -- whatever we  
9           develop today and tomorrow, how would we refine  
10          that before the end of the comment period?

11          **DR. ZIEMER:** We would either have to have a  
12          telephone conference or a real, face-to-face  
13          meeting, yes.

14          Tony.

15          **DR. ANDRADE:** Paul, I think it would be in  
16          our best interests to try to, as you said, draft  
17          something in terms of recommendations for  
18          wordsmithing this proposed rule, perhaps adding  
19          some clarification -- clarification of  
20          philosophy, what it's intended to accomplish, the  
21          whole idea of commonality that people are looking  
22          for, those sorts of things -- sooner than later.  
23          And then we can address the issue of finalization  
24          -- that is via teleconference or another meeting  
25          -- later on.

1           **DR. ZIEMER:** Yes, thank you.

2           I'm glancing here at our schedule to see  
3 whether or not there will be time to actually do  
4 some of that while we are here. There is,  
5 tomorrow afternoon, a fair block of time that  
6 could be devoted to this. It would require  
7 probably some preliminary work between now and  
8 tomorrow by one or two people to organize and  
9 categorize the comments that we had, and to come  
10 up with a scheme for how to approach that. It  
11 would probably preclude the Mark Griffon  
12 subgroup, which has its own task before it. But  
13 if there were one or two others that would be  
14 willing to spend a little time maybe after  
15 dinner, I'd certainly be glad to participate if  
16 we had one or two others, just so we can sort of  
17 organize the comments.

18           Any volunteers for that? Okay, Tony. Any  
19 others? Wanda. I've jotted down, I think, a  
20 good portion of them. Maybe you've made notes.  
21 Maybe we can -- you haven't made notes. Okay.  
22 Anyone want to replace Wanda on the committee?

23           (Laughter)

24           **MS. MURRAY:** Wanda, you can have my notes.

25           **DR. ZIEMER:** No, no, no, you -- she has it

1 all in her head.

2 **DR. ANDERSON:** Where are you going to meet?  
3 Depending on how much --

4 **DR. ZIEMER:** Well, I don't know. Where would  
5 you like to meet? We can meet in my room, I  
6 think. It's -- I think I've got three chairs and  
7 a bed. Okay. Let's do that after dinner and do  
8 some preliminary -- sort of lay out a scheme that  
9 might help the committee work together tomorrow.

10 But I don't want to preclude additional  
11 discussion on that right now, so again let me ask  
12 this question. Do you feel, with the  
13 clarifications you've heard today -- and I think  
14 some of you said, well, if that were said in the  
15 rule-making that would help, some of the things  
16 that were said -- and perhaps some -- I don't  
17 know, reformatting or reorganizing of some things  
18 that are in there to bring out certain points,  
19 and maybe some -- well, identifying those issues  
20 that need additional clarification, maybe that'll  
21 give us a start. And we can then work on that  
22 tomorrow and see where we end up, whether we are  
23 far enough along that we feel we'll be able to  
24 get a draft before mid-August.

25 But I want to make sure that we've identified

1 all the issues that people wish to raise. Not to  
2 say that you can't raise more later, but --

3 (No responses)

4 **DR. ZIEMER:** Okay. I'm going to, if it's  
5 agreeable with our members of the public who were  
6 originally scheduled for 4:30, if they're all  
7 here, I'd like to ask them if they would be  
8 agreeable to beginning this part a little early.

9 Richard Miller -- Rich, are you still here?

10 **MR. MILLER:** Yeah.

11 **DR. ZIEMER:** Robert Tabor?

12 **MR. TABOR:** Here.

13 **DR. ZIEMER:** Phillip -- Schofield, is it?

14 **UNIDENTIFIED:** He stepped out.

15 **DR. ZIEMER:** Okay. And Robert Bistline.

16 **DR. BISTLINE:** Yes.

17 **DR. ZIEMER:** Let's proceed, then.

18 Richard, would you go first? And why don't  
19 you come up to the podium. There's a lavalier  
20 mike there. You just need to snap it on.

21 **MR. MILLER:** I promised Phil he could go ahead  
22 of me. I think he's actually --

23 **DR. ZIEMER:** Do you prefer to have Phil go  
24 before you?

25 **MR. MILLER:** Well, I would, but I -- just to

1 avoid redundancy, also. Maybe we can do that.  
2 Why don't we --

3 **DR. ZIEMER:** That's fine. No problem.  
4 Phil?

5 **MR. MILLER:** Yeah, let's do that, and if he's  
6 not back in time I'll --

7 **DR. ZIEMER:** Oh, Phil's not in the room.  
8 Well, Robert Tabor, we'll let you go first.  
9 Is that all right?

10 **MR. TABOR:** Yeah. You want me to speak here  
11 or up there?

12 **DR. ZIEMER:** Go up there, that would be good.

13 **MR. TABOR:** I don't know if I'm totally  
14 prepared for this, but since I've been here a few  
15 times and we all put our pants on the same way,  
16 except for the ladies, I guess I'm comfortable  
17 enough with talking to you.

18 **DR. ZIEMER:** Robert, just for the record,  
19 tell who you're representing here.

20 **MR. TABOR:** Okay. I'm Bob Tabor, Robert G.  
21 for the record, whatever you want to put down --  
22 T-A-B-O-R. That's Tabor, like labor; a little  
23 pun there.

24 There's some things that I'd like to  
25 basically discuss. Maybe I can categorize the

1 issues. One is somewhat the issue of integrity.  
2 I've kind of picked up on this this morning, the  
3 integrity overall of the review process. I'd  
4 like to emphasize that I think a great deal of  
5 importance and attention needs to be paid to  
6 that. And let me give you an example.

7 For years the site that I work at, the  
8 Fernald site, and the people that I guess would  
9 be -- I would call my constituency, the Fernald  
10 Atomic Trades and Labor Council and those workers  
11 at the site, I remember when we first come there  
12 there was comments made -- well, there's no way  
13 you can get injured out here or anything to worry  
14 about out here. The only way you can get hurt is  
15 if a piece of uranium dropped on your head, that  
16 was about it. And there was even comments to  
17 that nature that were made in certain testimony  
18 during the lawsuits.

19 But obviously that's not the case in this  
20 industry, and it's not the case with the  
21 materials that we dealt with out there. But most  
22 of the people were, I think -- or at least  
23 myself, and I know a lot of folks that I could  
24 say this would be true of -- were told that there  
25 basically wasn't a whole lot of risk in this

1 business, and that you didn't have to worry about  
2 exposure. Well, that didn't end up being the  
3 case, as later on litigation and various types of  
4 studies that were done by maybe individuals like  
5 Arjun Makhijani did some things for, I think,  
6 some of the case suits that were filed against  
7 the company that ran the operation out there at  
8 the DOE. And the same was true, I think, with  
9 some of the workers in that case suit. And the  
10 Till study, I think, showed evidence contrary to  
11 what we were told were the risks and the  
12 potential exposures at our site.

13 And when you take that in consideration,  
14 maybe it indicates that our processes for  
15 accumulating the data could be -- I don't know if  
16 I want to say tainted -- but certainly sheds  
17 maybe some doubt on how we accumulated  
18 information and data for exposure information.  
19 And when you take that into consideration, and  
20 you look at the fact that -- I'm not a scientist,  
21 but a lot of these things like risks, you got a  
22 lot of statistics involved in projecting  
23 probabilities when it comes to exposure data.  
24 You're dealing with a lot of other ways that in  
25 my mind, in doing estimates, that really -- I

1           guess if I was some type of a legislative type of  
2           a person on top, I would look at this as being a  
3           very mushy type of business. And that's not  
4           saying anything against the scientists that do  
5           this, it's just -- I think it's the nature of  
6           things, that sometimes you can't be just really,  
7           really exact.

8           So now we have this process for trying to  
9           make things right out here and do something for  
10          those who paid the price during the Cold War for  
11          our freedom and what have you, and we have the  
12          situation of how we're going to go about this.  
13          And obviously there's still some questions that  
14          are unanswered. And some of these things, I  
15          think, that the Board will be playing a very  
16          valuable role in because now we're talking about  
17          hiring, what, some subcontractors to assist in  
18          the processing of the information or processing  
19          of things that a small group of people are not  
20          going to be able to do by themselves at NIOSH.

21          And I guess on a personal note I probably  
22          know some of those individuals that are going to  
23          be -- that these -- in these contractors that are  
24          looking at winning that bid. But on a note of  
25          integrity, I'm not so sure that as a labor

1 person, and I'm not so sure that other folks like  
2 me around the country in labor would say that  
3 maybe we trust any of those folks, because most  
4 of them -- that's my understanding currently --  
5 we're still talking about people who are paid by  
6 the government. And you know what that story  
7 means. There's going to be still a lot of  
8 distrust there. So now we're back to this  
9 situation on integrity.

10 If we're going to do right by these folks, I  
11 think that the processes really, really need to  
12 have a certain flavor integrity. And I think on  
13 that note, in my mind, that the role of this  
14 Advisory Board here is very, very important, that  
15 you people need to be in that process somehow.  
16 And I'm not getting necessarily the indication  
17 where there's some assurance that your role into  
18 the process of assuring that we can have that  
19 integrity across the board there.

20 And I think also it reminds me of a  
21 conversation not too long ago about some of the  
22 things that went on out at -- let me see, was  
23 that --

24 Your site. Where are you from again?

25 **MR. ESPINOSA:** Los Alamos.

1           **MR. TABOR:** Oh, Los Alamos. And some of the  
2 stuff out there, I think that it dealt with  
3 tritium. And there was a lot of question, as I  
4 believe, and I can't -- I'm no authority on that  
5 because I'm from Fernald. But you hear things  
6 elsewhere. But there was some issues concerning  
7 whether or not -- compliance issues relative to  
8 dealing with those materials and what have you.

9           And I guess my point is not until certain  
10 people got involved, some folks like maybe Till  
11 and Arjun got involved in some of that, was there  
12 any confirmation as to whether you are in  
13 compliance or whether you aren't, and whether the  
14 public trusted what was said or what wasn't. And  
15 the integrity in these processes, as far as I'm  
16 concerned, is really going to be important.

17           So the type of things that you've been  
18 talking about here today and the issues it seemed  
19 to like -- to allow to have a lot of black holes  
20 in this process. Those things really need to be  
21 looked at very, very thoroughly. When I listen  
22 to you I can understand what you're talking  
23 about, but it's very, very hard to, I guess I  
24 would say, reiterate or -- what that -- you know,  
25 what I mean by that.

1           One of the other areas that I wanted to bring  
2 up was like our Fernald situation there and the  
3 Special Exposure Cohort issues, and some of this  
4 most recent proposed rule-making. Fernald was  
5 not included in those special cohort group. I  
6 don't know how they managed to get left out of  
7 that because when I look at the fact that, well,  
8 what did we do there? Well, let's see, we  
9 received Paducah's material and we dealt with the  
10 same thing they did down there, and we received  
11 material from Portsmouth and we dealt with the  
12 same thing that they had there. Even though  
13 maybe some of our processes might have been a  
14 little bit different than those, some of the  
15 things that you were exposed to be identically  
16 the same.

17           And we'll have people there who are going to  
18 come up ill, come up with cancers, and by the  
19 nature of the Act they won't qualify there  
20 because it isn't this particular cancer or that  
21 particular cancer as defined in the Act. But if  
22 you look over at some of the things that would  
23 qualify individuals at Paducah or qualify folks  
24 at Portsmouth, they would certainly be comparable  
25 to. And yet I'm not certain how they would

1 explore their cases. I guess through the  
2 petitioning of -- saying that we believe we  
3 qualify for a particular class.

4 Things that come to my mind today as I was  
5 listening, I don't know if I can really explain,  
6 but we were talking a lot about -- somebody  
7 brought up this number, well, if we had 90 people  
8 and they didn't -- let's see, what was said --  
9 they couldn't do a dose reconstruction on them,  
10 and we put them over here in this pool and a  
11 certain period of time went on, and eventually we  
12 would look and see if there was some kind of  
13 commonality or something there and maybe take a  
14 relook at those things later. I'm thinking, why  
15 wouldn't you want to take a look at it from a  
16 group perspective on the front end rather than  
17 look at it from an individual perspective on the  
18 back side and wait a long period of time?  
19 Because sometimes these long period of times,  
20 folks, people are dead by the time they would  
21 ever be able to get reconsidered or get  
22 considered for these claims. And that was one of  
23 the issues.

24 I'm not sure that I believe that the proposed  
25 rule-making takes into consideration or doesn't

1 have some black holes there that allow some  
2 things to slide in the cracks. And I did hear  
3 some discussion from the Board members here about  
4 some proposals that possibly would plug those  
5 holes, so I would encourage you folks to do what  
6 you can to maybe shore up the ship there.

7           The last time I was here I brought up an  
8 issue concerning -- it was after a gentleman  
9 spoke from the National Cancer Institute, and  
10 still what comes to my mind -- and I would like  
11 to use the analogy of apples and oranges -- we  
12 may have bad data out here that we've accumulated  
13 over the years relative to exposures on people,  
14 and I just want to say data that we accumulated  
15 that we know applies to apples. And we say,  
16 well, I guess if this data applies to apples, I  
17 guess I can apply it to other fruit. But the  
18 truth of the matter is you can't apply what you  
19 know about apples to oranges. Simply because  
20 oranges are fruit doesn't mean you can apply it.

21           And I'm still not convinced that the kind of  
22 data that we've accumulated from the atom bombs -  
23 - Nagasaki, Hiroshima -- that the studies on the  
24 survivors, that that particular data really is  
25 applicable to what workers have been exposed to

1 in the nuclear network, and I still have some  
2 questions about that. There are a lot of other  
3 worker studies out there. I don't know exactly  
4 whether -- how we're looking at those things or  
5 if we are looking at those things. But we  
6 certainly should assure ourselves that we need to  
7 compare apples to apples and oranges to oranges.

8 There was one other thing that I had and I  
9 don't -- I'm trying to think here; I didn't get  
10 it jotted down.

11 Well, those were the three particular things  
12 that I had in mind. If I think of the other one  
13 I'll mention it. But with that, I guess those  
14 would be my comments.

15 **DR. ZIEMER:** Thank you very much. If you'd  
16 remain there just a moment, let me ask if any of  
17 the Board members have questions or items they  
18 want clarified here.

19 (No responses)

20 **DR. ZIEMER:** Okay. Thank you.

21 Did Phillip come back in?

22 **UNIDENTIFIED:** No, still not back yet.

23 **DR. ZIEMER:** Let's see, Dr. Bistline? You  
24 can go next.

25 **DR. BISTLINE:** I'm Dr. Bob Bistline with the

1 Department of Energy, Rocky Flats Field Office.  
2 And I just wanted to make a few comments to the  
3 Board here this afternoon, and I appreciate the  
4 opportunity, Dr. Ziemer and Board members.

5 My background is I've been at Rocky Flats for  
6 about 36 years, a little over 36 years, and  
7 worked on the contractor side in their internal  
8 dosimetry, lung counting and so forth, and  
9 started a study back in 1980 bringing back old  
10 retired workers from the plant that had known  
11 depositions of plutonium or had exposures greater  
12 than 20 rem dose, overall external dose, and  
13 recognized some of the problems with the  
14 dosimetry of the program at Rocky Flats. And so  
15 started that program in 1980. I had about 900  
16 individuals that I was bringing back to the site  
17 every three years for physical exams.

18 I presently work for the Department of  
19 Energy, have been there with the Department of  
20 Energy for about a little over seven years now  
21 heading up the internal dosimetry oversight,  
22 occupational medicine oversight, and the  
23 beryllium program oversight.

24 But I want to concentrate, and appreciate any  
25 helpfulness that can be given by the Board, in

1 terms of clarification of the SEC part of it. I  
2 know Henry and Jim and Tony have addressed some  
3 of those issues as it stands, and I bring out the  
4 point that we are seriously considering at Rocky  
5 Flats looking at Special Exposure Cohorts in a  
6 couple of areas.

7 One particularly that stands out -- and if  
8 this is not the intent of it, we certainly would  
9 like to hear, because I'm struggling with that  
10 clarification myself -- things like the fact that  
11 before 1964 we had no lung-counting capability.  
12 And we know now from our experiences with  
13 plutonium and the insolubility of the material  
14 that if you didn't have lung-counting  
15 capabilities, we're now finding some of these  
16 old-timers that worked back in the fifties and  
17 sixties showed no indication of bioassay,  
18 positive bioassays, and had very little external  
19 exposure recorded for them; that now, lo and  
20 behold, we brought in a 92-year-old gentleman  
21 here a while back, and he's got quite an  
22 extensive lung deposition of plutonium. And so  
23 there's a whole cohort of population before 1964  
24 that we have no internal dosimetry in terms of  
25 lung counting.

1           Prior to 1957 there were only 18 people out  
2 of the entire population at the plant that had  
3 ever been given neutron dosimeters. There is a  
4 neutron dose reconstruction project, and I know  
5 Larry -- Mr. Elliott and the crew are looking at  
6 that. Some of that data is -- we're making  
7 progress on re-reading some of the films, but  
8 there isn't even data available on some of these  
9 people.

10           And so there are very specific types of  
11 cohorts here that I'm concerned, we're concerned  
12 about. And I think that those kinds of nuances  
13 probably occur throughout the nuclear industry,  
14 the Department of Energy, with different sites.  
15 And I would hope that -- and I don't know how  
16 extensive that's going as far as capturing the  
17 unique information that is lacking at the various  
18 sites, the historical information that some of us  
19 know about.

20           And I know the NIOSH people are trying to  
21 explore that, and I certainly would encourage any  
22 information that they can gain by various  
23 sources. And maybe through the public comment at  
24 stakeholder meetings and so forth they could  
25 capture some of that through some of the old-

1 timers that could provide additional information  
2 along the dosimetry lines, because there is a lot  
3 of information that's lacking in, I think, all  
4 the sites. Probably we're not unique at Rocky  
5 Flats. I know other sites are struggling with  
6 some of the same things that -- to try to go back  
7 and capture the exposures of individuals back in  
8 the 1950's and sixties is next to impossible.

9 And on internal dosimetry of plutonium, with  
10 the insolubility and the various differences that  
11 you find, just going to a fellow worker and  
12 looking at a fellow worker, it doesn't  
13 necessarily give you anything in terms of  
14 internal deposition. We've found at Rocky Flats  
15 where we're doing a lot of hands-on work, and I  
16 think this is a unique population at Rocky Flats  
17 because these guys have been doing hands-on work  
18 with plutonium for years. In fact, we still have  
19 over 12 tons of plutonium out there right now.  
20 And these are the guys that made almost all the  
21 nuclear weapons in the Defense Department over  
22 the years. And we know that some of these guys,  
23 two guys standing side by side, one guy can be  
24 pumping the gloves and be pumping, and a hole in  
25 the glove, and that guy gets an intake; and the

1           guy next to him, standing shoulder to shoulder  
2           with him, comes up with nothing. And so you  
3           can't really rely on fellow workers as an  
4           indicator of internal uptakes in a lot of cases.

5           So I just bring those points out to the  
6           Board, that there's a lot of uniqueness with  
7           working around a facility like that. And I  
8           certainly hope that all the information possible  
9           can be captured in terms of historical knowledge  
10          of the dosimetry. And I know Larry and people  
11          are anxious to capture as much of that as  
12          possible, but unfortunately at a place like Rocky  
13          there aren't very many of us old-timers around  
14          anymore that have the historical knowledge of the  
15          site and the dosimetry. Most of the guys that  
16          work out there now in closure, most of the old-  
17          timers are gone. And it's guys that have worked  
18          there less than five years, or five to ten years  
19          is the lifespan of most of those guys.

20          So I just encourage you, that the Board work  
21          on trying to get a little more clarification in  
22          some of these areas that would certainly be  
23          helpful to some of us in considering whether  
24          Special Exposure Cohorts would be appropriate to  
25          pursue. Thank you.

1           **DR. ZIEMER:** Thank you very much.

2           Again, let me ask if there are questions or  
3 clarifications? I might ask one question. I  
4 assume now on these ones where you're going back  
5 and doing the lung counts, assuming some kind of  
6 a clearance model, you can reconstruct doses then  
7 on them?

8           **DR. BISTLINE:** It's -- yeah, you can do a  
9 pretty good job of it if you capture those. But  
10 unfortunately, like in this particular  
11 individual, it just so happens that he's 92 years  
12 old. He left the plant site before we ever got a  
13 lung counter. So we are able to go back on that  
14 individual. But there's a lot of people that are  
15 no longer living, and a lot of people that worked  
16 at the site that aren't a part of this particular  
17 recall cohort. And so many of those people have  
18 never been lung-counted, historically never have  
19 been lung-counted. But yeah, Dr. Ziemer, we have  
20 been able to go back and get a fairly good range  
21 of dose that this -- the internal uptake from the  
22 dosimetry models on this individual.

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

24           **DR. ANDRADE:** I'm curious, sir. In your  
25 follow-up bioassay, is it only lung counting that

1 you are performing, or are you doing any special,  
2 say, urinalysis or --

3 **DR. BISTLINE:** Yeah, we're doing urinalysis  
4 and the lung counting both. The reason why  
5 that's particularly important, because at Rocky  
6 Flats we have quite a cohort of population that  
7 has been exposed to what you would call high-  
8 fired plutonium oxide.

9 And just to give you a good example, one of  
10 the individuals that I did an autopsy on back a  
11 number of years ago -- I've done autopsies on  
12 about 120 people from Rocky Flats, former workers  
13 -- and one of these individuals was involved in a  
14 fire in 1965 with high-fired plutonium oxide, and  
15 there were a number of people -- in fact, there's  
16 quite a few people -- that have been exposed to  
17 this type of material. At the time of this  
18 autopsy, 20 years post-exposure, almost 20 years  
19 post-exposure, at the time I did the autopsy he  
20 had 222 nanocuries of plutonium, 48 nanocuries of  
21 americium still in his lungs and lymph nodes; and  
22 in all the rest of the body -- the soft tissues,  
23 the bones, et cetera -- less than 10 nanocuries  
24 after 20 years. So the models that exist out  
25 there for transport of plutonium in the case of

1 high-fired oxides have absolutely no relevance  
2 whatsoever.

3 **DR. ANDRADE:** Right. I completely agree in  
4 that particular case. And, furthermore I wanted  
5 to ask you if you had tried any of the ultra-  
6 sensitive techniques with some of the folks --  
7 for example, mass spectrometry, whether it be  
8 thermal or inductively-coupled plasma?

9 **DR. BISTLINE:** We haven't done that with any  
10 of the folks at Rocky that I'm aware of. I don't  
11 think anybody has tried that with any of those.  
12 Back in 1967 I started up with the -- converting  
13 over to germanium, hyper-pure germanium detectors  
14 for lung counting. But as far as looking at the  
15 bioassay with some of these newer techniques, no,  
16 we haven't. Only just on a few people, isolated  
17 people.

18 **DR. ANDRADE:** The last point I'd like to make  
19 is just simply a comment. I think that this is  
20 precisely the type of case that I think one  
21 would, in my opinion, would be considered for a  
22 special cohort status, because new information  
23 has come to light about an activity that was  
24 common to many, many people for many, many years  
25 that we perhaps never kept any formal records on.

1 So I wish you the best.

2 **DR. BISTLINE:** Yes, Wanda.

3 **MS. MUNN:** I haven't looked at the data  
4 myself. Do you have a significant number of  
5 excess lung cancers or other related cancers that  
6 you've been able to identify with exposure?

7 **DR. BISTLINE:** Not really. I was talking to  
8 Dr. Ziemer, I think, earlier, and Dr. George  
9 Voelz at Los Alamos and I went back a couple of -  
10 - well, about two years ago went back and looked  
11 at a lot of the old-timers that were exposed back  
12 in the fifties and the sixties at Rocky Flats and  
13 some of the workers at Los Alamos that had been  
14 published, and no real follow-up had ever been  
15 done. And when we went back, well, it turns out  
16 a good many of these people are still living, and  
17 turns out that the guy that got the second most -  
18 - I talked about the 222 nanocuries and 48  
19 nanocuries. Well, the other guy -- there were 25  
20 that had greater than maximum permissible lung  
21 burdens, which was the old terminology that was  
22 used. The second-highest guy just passed away  
23 about a year and a half ago, and he was 87 years  
24 old and died of complications of surgery.

25 **MS. MUNN:** Which is sort of confirmation of

1 the original PU club --

2 **DR. BISTLINE:** Yeah.

3 **MS. MUNN:** Figures. Thank you.

4 **DR. BISTLINE:** Very much so, Wanda.  
5 Yes.

6 **DR. ZIEMER:** Jim.

7 **DR. MELIUS:** Yeah. Just to follow up on  
8 Tony's comment, I also would think this would --  
9 description would suggest a parameter that could  
10 be used to describe a type of cohort that would  
11 be considered, type of class group that would be  
12 considered for a Special Exposure Cohort, and  
13 could give some guidance to other groups out  
14 there in this way.

15 The other question actually is more for  
16 Larry, if I word this carefully, but I'll use  
17 your terminology. Has NIOSH developed any sort  
18 of process to gather a group of old-timer experts  
19 to help, assist at each site with understanding  
20 the availability of data and so forth? Because I  
21 think that would certainly be obviously very  
22 useful at a site that would be -- where you were  
23 doing dose reconstruction, and also valuable in  
24 terms of even where you're fairly certain about  
25 your access to information in terms of the

1 Board's review of those dose reconstructions,  
2 that yes, all the relevant information was  
3 obtained, nothing was missed. And if we could  
4 have a roster of that group of people, I think it  
5 would be worth the investment to try to put that  
6 together now and for use later. Obviously with -  
7 - not at every site, but certainly at many of the  
8 major sites it would be useful, because we are  
9 losing those people, particularly at sites closed  
10 down and so forth.

11 **MR. ELLIOTT:** I'm very familiar with the loss  
12 of the people, having served ten years in the  
13 research program and wanting to talk with many  
14 people. Louise Presley's father was one I wanted  
15 to talk to before he passed away. He was very  
16 integral to a lot of industrial hygiene work that  
17 went on in Oak Ridge and K-25, and we missed the  
18 opportunity.

19 No, we have not put a roster together. In  
20 our statement of work for the contractor this is  
21 a research effort that they will take on for us,  
22 and it's building site profiles for a given site.  
23 And again, I apologize for the excuse, but I  
24 don't have enough staff to do dose  
25 reconstructions at hand and build site profiles

1 and interview the people that we need to  
2 interview. So we are -- I think it's important  
3 to note, though, that as we conduct these  
4 interviews of the claimants we are finding that  
5 they direct us to other individuals who knew  
6 about particular dosimetry program, historical  
7 changes in those, and we're pursuing that along  
8 with the case as we proceed with the case  
9 development.

10 **DR. ZIEMER:** Any other questions?

11 (No responses)

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

13 Phil Schofield, you want to address us?

14 **MR. SCHOFIELD:** Yeah, I have a couple of  
15 things, comments I'd like to make on --

16 **DR. ZIEMER:** Phil, for the recorder here,  
17 just tell where you're from and --

18 **MR. SCHOFIELD:** Okay. I'm Phillip Schofield.  
19 I used to work at LANL for 21 years. I'm with  
20 the project, Los Alamos project on worker safety.  
21 Particularly I'd like to address some  
22 concerns I have about the special cohort. One of  
23 them is that it says that the petitioner must  
24 have and include positive evidence the records  
25 required to do dose reconstruction do not exist.

1 I would like -- I think if the petitioners have  
2 done everything they can, they have requested the  
3 records in a timely fashion, if they have tried  
4 to access records and have either been denied or  
5 the contractor or DOE, whoever it is who owns  
6 those records, has not delivered them in a timely  
7 fashion, then by default they should be allowed  
8 into the special cohort.

9 And a reasonable time effort, I think, would  
10 be -- because a number of people we have run into  
11 have had this problem. I, myself, I've been  
12 after my exposure records for almost six months  
13 now, and I still do not have them. At some point  
14 there has to be some teeth that the contractor  
15 has to either deliver or pay some kind of  
16 penalty. And if they don't deliver -- because  
17 you're asking someone to prove a negative,  
18 saying, well, these records don't exist. Well,  
19 they may exist. But if you can't get those  
20 records, then you can't prove it. The other  
21 thing is that when these records are missing or  
22 they have not been brought forth, the burden of  
23 proof would then shift from petitioner to NIOSH  
24 and Department of Labor rather than the  
25 petitioner about these facts.

1           The other problem I have is when we get into  
2 the thing about the cancer, you can have two  
3 people working side by side and one may develop  
4 liver cancer, one may develop lung cancer. This  
5 has been my experience working in the field, is  
6 that we've had people I've worked with, some of  
7 them died of one cancer, some died the other.  
8 Yet we all worked in the same areas. In many of  
9 these areas it's going to take a concentrated  
10 effort by whoever does this dose reconstruction  
11 to do what is a fairly accurate job. And we need  
12 to have a legal point at which people can say,  
13 okay, I can meet this criteria or I cannot meet  
14 this criteria. But if you have a moving target  
15 they can say, well, you didn't get enough  
16 exposure here, you didn't get enough exposure  
17 there.

18           But just using dosimeter badges is flawed,  
19 from my personal work history. I can tell you  
20 there are people who are running around there who  
21 have badges that are biased towards gamma, and  
22 yet had a lot of neutron exposure. But you will  
23 not see that. Same, very same thing, we have  
24 various -- we have processes where you had a high  
25 neutron flux, like HF reduction, on the same --

1 and you had people over there doing direct oxide  
2 reduction. That's basically gamma. And then you  
3 had people working with americium. They're  
4 getting both of it. But if you look at their  
5 exposure records, it does not reflect these  
6 matters.

7 And the other thing is we have some special  
8 classes, I think, that need to be looked at,  
9 because you take a lot of the crafts, a lot of  
10 the guards, what they call laboratory services  
11 inspectors. They would go through an area, and  
12 in one shift they could get exposed to plutonium,  
13 americium, uranium, and who knows what all --  
14 238, 239, 243, 241, americium -- all in one  
15 eight-hour shift. So how do you reconstruct  
16 these doses that are accurate enough to reflect  
17 what these people have been exposed to?

18 That's my comments. Thanks.

19 **DR. ZIEMER:** Thank you very much.

20 Let's see if anyone has questions or items  
21 you want clarified.

22 Yeah, Tony.

23 **DR. ANDRADE:** Phil, when you requested your  
24 own exposure records, did you request them for  
25 the purpose of this program alone, and/or did you

1 request a copy of your records for yourself?

2 **MR. SCHOFIELD:** Both for this program and for  
3 myself, because -- let me give you another  
4 example. There is very strong distrust of  
5 LANL/DOE there among the workers. I have a  
6 document by the nurse, Jan Crosdale, at TA-55 --  
7 she was our site nurse -- talking about when I  
8 was getting radiation poisoning, as Dr. Williams  
9 referred to it. My hair was falling out. I was  
10 having skin problems. It was turning red.  
11 Little blood vessels were breaking down. So I  
12 saw her. I have that document. But when I went  
13 to see him a week or two later, he put all -- he  
14 was putting this stuff in my file. You won't  
15 find that file anymore. Now doesn't it seem a  
16 little bizarre that I've got the one from the  
17 nurse, but the one from the LANL medical doctors  
18 no longer exist? Tell me who I trust.

19 **DR. ZIEMER:** Okay. Thank you, Phil.

20 And then Richard Miller is going to come back  
21 to the podium now.

22 Richard? The first shall be last.

23 **MR. MILLER:** Good afternoon. I'm Richard  
24 Miller, here today. I work for the Government  
25 Accountability Project in Washington, D.C., and I

1 would like to run through several questions,  
2 first regarding the Special Exposure Cohort rule.

3 I wanted to first thank the NIOSH staff.  
4 They were kind enough, as alluded to earlier  
5 today, to convene at least a small group of us in  
6 Washington last week to try to gauge reaction, I  
7 guess, to the draft rule. There has certainly  
8 been a lot of interest and anticipation, because  
9 this aspect of the legislation is really at the  
10 heart of whether this law is going to work or  
11 not.

12 It's at the heart of it for this reason.  
13 When I had the pleasure, I guess, and the honor  
14 of representing a number of nuclear weapons  
15 production workers and their survivors during the  
16 legislative process, and when the debate came  
17 about about whether this bill should look like  
18 RECA and the benefit of the doubt -- rather, the  
19 presumption should just go to the claimant for  
20 the list of cancers or illnesses across the  
21 board, whether it -- and the answer that came  
22 back was, well, where it's clear-cut now we'll  
23 put people in the special cohort, but we want  
24 this to be a science-based program.

25 And so then the question was, okay, and what

1 happens if the data isn't there to do the  
2 science? And given that the hearing after  
3 hearing after hearing had demonstrated the  
4 absence of quality data, the absence of adequate  
5 monitoring information, the intent in some cases  
6 consciously not to monitor, in other cases  
7 records were missing. There was the wonderful  
8 story that was told about what happened to some  
9 of the data from Amchitka Island that I think  
10 wound up in one of those really cold, cold oceans  
11 off of -- between Alaska and the mainland.

12 But the core of this program is in the  
13 Special Exposure Cohort, because that's the only  
14 people -- only way people are going to ever feel  
15 as though, at the end of the day, if the data  
16 isn't there to reconstruct the dose -- and it's  
17 because the government failed to fulfill, or  
18 through its contractors, certain obligations --  
19 that they aren't at the end of the day left  
20 holding the bag, and it's their fault because the  
21 data isn't there to make the case affirmatively.  
22 That means that broad presumptions and people are  
23 going to be compensated, right, for whom one  
24 could statistically say they may not have  
25 actually been harmed.

1           But there's a very powerful equity issue at  
2 work here. This isn't just a science question.  
3 It's a question of equity at the end of the day.  
4 And that's why the special cohort process exists,  
5 and that was the grand compromise, in a sense,  
6 not only about how much did this program cost,  
7 but about what are you going to do for those  
8 people who would fall through an awful lot of  
9 cracks that exist out there.

10           With that in mind, I want to just express  
11 some concerns with several aspects of the SEC  
12 process or proposed rule. And the first has to  
13 do with, as Ted and Larry have heard, what do we  
14 -- why is it that the threshold for endangerment  
15 is set at the level for 50 percent of the way  
16 between leukemia and the next most radiosensitive  
17 tumor?

18           And what comes to mind is a colleague of Phil  
19 Schofield's, Joe Garcia -- and I don't have the  
20 transcript today, but I want to try to get the  
21 transcript to you all, of a hearing that was held  
22 in Los Alamos on May 11th of this year. And Mr.  
23 Garcia worked in the hot dump in Area G, and he  
24 had leukemia, came down with leukemia after  
25 beginning employment a significant number of

1 years later. He had a bone marrow transplant.  
2 He's obviously incapacitated and can't work, but  
3 he's alive. And as he's described it, at least,  
4 there's very little data to support his exposures  
5 from having worked in Area G.

6 Now if the hot dump turns out to be -- and  
7 I'm not saying it is or it isn't today -- but if  
8 the hot dump turns out to be a good candidate for  
9 a Special Exposure Cohort group because it's not  
10 feasible to really estimate the dose, and Mr.  
11 Garcia is your lead petitioner and Mr. Garcia has  
12 leukemia, and it's not -- and in the process of  
13 coming up with what is your sort of maximum  
14 possible estimate of radiation dose you don't  
15 come up with a radiation dose -- if you come up  
16 with a radiation dose that's well above what he  
17 may -- for what you could estimate he may have  
18 had at its worst case potential, I guess  
19 (inaudible) when you use the word "worst case"  
20 it's sort of this maximum estimate process --  
21 then he as a petitioner is going to find himself  
22 locked out of the cohort.

23 Now when we challenged, why set leukemia, and  
24 the answer is, well, it could be as low as one  
25 and a half rem of exposure -- and that seems

1           absurdly low; the charts that I have do vary  
2           anywhere for chronic myeloid leukemia from 1.2  
3           rem to 19 for certain kinds of other types of  
4           leukemia at age 40, when that was your exposure.  
5           But at the other hand there's an equity question.  
6           Does the statute say in its two-pronged test  
7           where it's not feasible to estimate dose and  
8           people may have been endangered, does it say they  
9           may have been endangered except if you have  
10          leukemia? Are they carved out of the process by  
11          statute? I think not. I think there's nothing  
12          in the legislative intent that says you carve  
13          those people out.

14                 Now the response we get back from NIOSH, in  
15                 all fairness to staff, is, well, it's not a very  
16                 popular cancer, and statistically it doesn't turn  
17                 up all that often. And so, geez, it's -- so a  
18                 few people fall through the cracks. And you can  
19                 really take that attitude pretty easily until  
20                 you're face to face with people who've been  
21                 through it. And then it's different. And then  
22                 all of a sudden that statistical explanation  
23                 doesn't make any sense.

24                 So when you go to Los Alamos -- I hope you'll  
25                 have the opportunity to meet with Mr. Garcia and

1           hear him face to face, and see whether or not it  
2           makes sense to him to carve him out of a Special  
3           Exposure Cohort if he doesn't fall through this  
4           algorithm. But he's got leukemia. He's got one  
5           of these rare cancers. But you all have to sort  
6           of put your hands on the scale, it looks like, to  
7           say that number's too low, can't go there. That  
8           number's just too low. We've got to come up with  
9           something a little bit more plausible. And so  
10          you've come up with this algorithm of 50 percent  
11          of the difference between the next radiosensitive  
12          tumor. Well, I hope his potential exposure falls  
13          above that threshold, but all I can say is I  
14          don't see any legal authority for you to do what  
15          you did. I think you made it up, and it doesn't  
16          look right when you view it through the lens of  
17          potential -- people who have leukemia.

18                 I also wanted to raise sort of a point about  
19          a suggestion that Dr. Anderson raised, which was  
20          this idea of claimants who have concerns about  
21          how the dose reconstruction process is going.  
22          And I -- by the way, this is not to say that I  
23          don't think it's going to go well. But let's  
24          just assume, for the sake of argument, people are  
25          in it, and they've been going back and forth with

1 NIOSH, and lo and behold, they just don't feel  
2 like the right quality of work is being done by  
3 the contractor, and they don't feel like the data  
4 that they know should exist is being chased down.  
5 Why not give them an opportunity to come to this  
6 Board through some formal process?

7 This is not to circumvent the adjudicative  
8 process with the Labor Department in any respect.  
9 The Labor Department's adjudicative process is  
10 very, very clear. What it says is after you sign  
11 OCAS-1 you go over there and you're turned down,  
12 you can file an appeal. The only thing the  
13 administrative hearing officer's going to deal  
14 with is was or wasn't this reasonably based, and  
15 then they'll remand it back if they determine  
16 that it was not reasonable. Well, they will not  
17 get involved in the Labor Department in any  
18 substantive analysis or assessment of the quality  
19 of the dose reconstruction. They will not get  
20 involved in the substantive what should the  
21 number have been as opposed to the number that  
22 NIOSH and its contractors came up with.

23 So I like that idea. I heard sort of  
24 murmurings of how much work did you expect this  
25 Board to do at certain points in terms of 90

1 petitions, and now we're going to be reviewing  
2 all this dose reconstruction and we're going to  
3 have a major undertaking in terms of review. But  
4 I think that's a really great safety valve. And  
5 I don't know what the lawyers are going to say  
6 about it, but in terms of the role of the Board,  
7 I think that would be a really valuable way to  
8 give people a sense that they're not boxed in  
9 without a place to come when they think things  
10 are off-track. And I don't know what the  
11 criteria is to let them in, because you could be  
12 inundated with those things on the other side.

13 In addition, I wanted to just point out one  
14 suggestion which I mentioned to Mark Griffon, but  
15 I want to offer to you all. There's one  
16 statutory criteria that was excluded from the  
17 proposal in the review, in terms of the Board's  
18 job in reviewing dose reconstruction. Under  
19 section 36.23 subpart (d)(2), it says:

20 (Reading) The President shall establish an  
21 independent review process using the Advisory  
22 Board on Radiation and Worker Health, one, to  
23 assess the methods established under paragraph  
24 one, which are your guidelines, and two, to  
25 verify a reasonable sample of the doses

1 established under paragraph one.

2 And this notion of having a feedback  
3 mechanism into your dose reconstruction rule-  
4 making and guidelines is very much contemplated  
5 in the statute. It wasn't necessarily presented  
6 today, and I understand why. But I just wanted  
7 to make sure it was on the record that that part  
8 ought not get left out when you finalize your  
9 report to the Board.

10 I had some suggestions with respect to the  
11 definition of feasibility. One of the concerns  
12 that we have, at least, is that the statute says  
13 that you have to not only determine whether it's  
14 feasible to estimate dose with sufficient  
15 accuracy -- there's a lot of emphasis that's been  
16 put on the sufficiency of accuracy.

17 "Feasibility" is its own weasel word, kind of  
18 like the "reasonable likelihood" weasel word, and  
19 there's all these fuzzy terms in the statute  
20 which Congress charged you with trying to figure  
21 out. And we think feasibility ought to account  
22 for some reasonable notion that at some point too  
23 long has transpired in getting enough information  
24 to make a decision.

25 Now Phil Schofield touched on this a bit, and

1 I had some sort of very specific suggestions in  
2 this area. What happens if NIOSH requests from  
3 our friends at the Energy Department records on  
4 groups of workers, and the data is not  
5 forthcoming after three months, after four  
6 months, after five months? Or the data that  
7 comes in is so incomplete that you can't really  
8 work with it. At what point does NIOSH say it's  
9 not -- we can't come up with a reasonable  
10 estimate because we don't have data?

11 Now there could be any number of reasons why  
12 it's not forthcoming. But that's not -- it's not  
13 a question of second-guessing people's good faith  
14 here. The question is, from a claimant  
15 perspective, how long is too long for NIOSH to  
16 wait? Is a year too long for it to wait? Is two  
17 years long for it to wait? At some point it gets  
18 to the ridiculous, right? I don't know where the  
19 point of the ridiculous is, but I think there  
20 needs to be an outer bound at which NIOSH says we  
21 can't do the dose reconstruction because the  
22 information hasn't come across the transom to our  
23 contractors. And otherwise, claimants are left  
24 holding the bag, and they're -- they may call  
25 your 800 number, but there's got to be more than

1 that. There's got to be a cutoff point.

2 Shifting gears, I'd like to just spend a  
3 minute on a process issue that arose out of the  
4 last meeting, and I want to commend Larry for his  
5 good efforts at trying to get some key  
6 information that got into our hands at the end of  
7 last meeting which had to do with the CIRRPC,  
8 comparison between the CIRRPC or the 1988  
9 screening dose information -- I think the copy of  
10 that report was circulated -- and the IREP model.  
11 I don't know if any of you have had a chance to  
12 compare the two, but I thought I would just put  
13 it up on the viewgraph here for a moment.

14 Now this is from Charles Land's report. Now  
15 this particular chart, I assume it's the same as  
16 in the final report -- I didn't double-check it -  
17 - that we were given dated June 11<sup>th</sup>. But this  
18 comes from the January 24th report prepared by  
19 NCI. And I just wanted to do some comparisons  
20 here for a moment and then raise a question.

21 In the first column is the 1988 CIRRPC  
22 report, as it's known. And this is what is used  
23 by the Veterans Administration for both screening  
24 and compensating people under the atomic veterans  
25 program for certain cancers and under certain

1 circumstances.

2 The middle column is -- and this number here,  
3 adjusted for a particular factor that was  
4 introduced, the center column there, and that  
5 factor has to do with reducing the baseline risks  
6 of the U.S. population. And in this case CIRRPC  
7 reduced it to, I think -- when they set the  
8 probability of causation they reduced it to ten  
9 percent of the baseline risk for all counties for  
10 each particular type of cancer.

11 And over here is IREP, which is -- and I  
12 assume these numbers are fairly close to what  
13 NIOSH used. And you can see by looking at the  
14 numbers, both in leukemias in solid tumors, that  
15 there was a significant increase between the  
16 CIRRPC numbers. Let's just take esophagus.  
17 Atomic veterans would be compensated at about 3.9  
18 if they were exposed at age 20 at the 99 percent  
19 confidence interval, and you compare it with the  
20 IREP model, which I believe is 45. And so you  
21 see a jump here of, I don't know, maybe a 12-fold  
22 increase. And you can sort of get a feel for  
23 what my point is, which is that this is this  
24 interesting increase in eligibility criteria for  
25 the amount of radiation you have to get to get

1 compensated under two different programs  
2 involving radiation compensation.

3 This obviously left us with a lot of  
4 unanswered questions, and we went back to Larry  
5 to ask if we -- and to Kathy Rest -- if we could  
6 get a copy of what explains this particular  
7 differential. And we just received that by  
8 e-mail. I guess last Thursday I got a copy.  
9 Others had requested it from Congress as well.  
10 And there was a second set of data that we've  
11 been asking to get, which is the baseline risk  
12 data that was originally in IREP 2.1 and which  
13 was not available on-line, at least in the on-  
14 line version, of the risk coefficients of the  
15 excess relative risk per sievert for the various  
16 cancers. And so we're looking forward to getting  
17 that information; hopefully that will be in the  
18 pipeline soon. That will allow us, I think, to  
19 potentially cross-walk what's going on here  
20 exactly.

21 Now Dr. Land had laid out in the report that  
22 you all received a set of explanations for why  
23 there's this significant jump, and I think it  
24 would be worthwhile for the Board to spend some  
25 time with a diversity of perspectives debating

1 that. But I'm just going to raise a slightly  
2 different issue, because I'm really not qualified  
3 to get into the debate, which is the equity  
4 question. And I think it's a question of should  
5 this Board even look at the equity question.

6 Is it appropriate for an individual, say, at  
7 the Nevada test site who happened to be an atomic  
8 veteran who was there for a particular blast to  
9 be compensated at one level of excess relative  
10 risk per, say, sievert, compared with anywhere  
11 from three to 20 times higher amount of radiation  
12 required for an individual who happened to be  
13 working at the Nevada test site going in after  
14 the blast, or anybody who worked at Hanford or  
15 Idaho or anywhere else for that matter? I find  
16 it inexplicable how to deal with this. I don't  
17 have a suggestion.

18 But I, for one, am going to have a really  
19 hard time trying to explain to somebody who's got  
20 lung cancer, since that's the most common form of  
21 cancer leading to fatality, how you can wind up  
22 with a jump anywhere from 15 to 51; or given two  
23 very important factors, which are that most of  
24 the cancers, not all, but most of the cancers  
25 from the most updated atomic bomb survivor data

1 would favor the claimant because they're based on  
2 cancer incidence as opposed to cancer mortality,  
3 and because of the way that doses were estimated  
4 using the more recent DS-86 estimation for the  
5 atomic bomb survivors.

6 I think the Board ought to take a look at  
7 this question, and I think the Board ought to be  
8 pondering how it can be blessing a system for  
9 compensation where the outcomes are so radically  
10 different for potentially similarly-situated  
11 individuals. Because there's nothing in the  
12 statute that specified that you wound up with the  
13 results you wind up with under the NIOSH-IREP  
14 today. But this is -- it lays out here as a  
15 backdrop. It is applied as we speak today by the  
16 atomic veterans program for their compensation  
17 system. And when they were questioned about it,  
18 they clearly see they've got serious equity  
19 problems on their hands. So I just thought I  
20 would add that for discussion purposes.

21 **DR. ZIEMER:** Richard, could you show -- what  
22 does the top of that slide say? Could you just  
23 slide it down?

24 **MR. MILLER:** Yeah, and I'll tell you, they  
25 Xeroxed it wrong. They put the top of the paper

1 --

2 **DR. ZIEMER:** Oh, I see.

3 **MR. MILLER:** I apologize. It's the very last  
4 table in the report dated June 11th, and it is  
5 Appendix -- I think it's table E-4. Is that  
6 right?

7 **UNIDENTIFIED:** E-4.

8 **MR. MILLER:** Yeah, I think they Xeroxed the  
9 title off, unfortunately.

10 **UNIDENTIFIED:** Page 110.

11 **MR. MILLER:** And this is on the June 11th  
12 draft that you received.

13 **DR. ZIEMER:** I've got it.

14 **MR. MILLER:** My last -- do you want me to  
15 take a moment, Dr. Ziemer, to -- should I stop  
16 here?

17 **DR. ZIEMER:** No, I found it.

18 **MR. MILLER:** Last, I just want to underscore  
19 the last issue which is from the outside, at  
20 least, as we've mentioned, I think, on several  
21 occasions in earlier meetings, concerns about --  
22 our concerns, at least, about the potential for  
23 conflict of interest in the selection of  
24 contractors.

25 And I know that NIOSH is working hard on

1           trying to get this contract awarded, and I know  
2           they've had some bumps on the road. But at the  
3           end of the day we're going to wind up with  
4           somebody who's dependent on the Energy Department  
5           for their income doing the dose reconstruction in  
6           some significant -- to some significant degree.  
7           And whether it's Battelle or whether it's SAIC or  
8           whether it's Oak Ridge Associated Universities,  
9           these folks get their bread and butter there.

10                   And I really think it's very important that  
11           when you think about selecting somebody to do the  
12           work of assisting this committee in its  
13           independent review process, that the word  
14           "independent" means they have no contractual  
15           relationships with the Energy Department. The  
16           word "independent" has to mean something in the  
17           statute, and I would hope it would mean at least  
18           that. The statute made it clear the DOE wasn't  
19           supposed to do the dose reconstruction, but now  
20           DOE contractors are doing it. Maybe that's  
21           unavoidable.

22                   But in terms of integrity, which Bob Tabor  
23           harped on, there are only a handful of people out  
24           there, at least in the United States that I know  
25           of -- and I can't speak to people overseas --

1 that fall into that category. And John Till's  
2 name has been kicked around. Dr. Makhijani's  
3 name has been kicked around. They've made  
4 friends and enemies out there. But the one thing  
5 that an awful lot of people, I think, believe is  
6 that people of that caliber, their integrity's  
7 unimpeachable.

8           And I would certainly hope that if this  
9 committee makes a recommendation, they get  
10 somebody who advises and assists you in your dose  
11 reconstruction reviews who is completely beyond  
12 reproach so that there's nobody can say at the  
13 end of the day that there's any aspect of the  
14 dose reconstruction process that ultimately  
15 doesn't speak to the credit of NIOSH. NIOSH is  
16 much stronger and in a much stronger position  
17 when it denies claims if the likes of Dr.  
18 Makhijani or Mr. Till come in and say this was a  
19 credible process. At that point it's really hard  
20 to bark at it, and I know that was certainly the  
21 intent in how they were used in other  
22 circumstances. And I hope you'll consider -- it  
23 doesn't have to be them, but it's an awfully  
24 small pool to fish from out there, and we all  
25 know who everybody is.

1           So I would just offer you, it's got --  
2           they've got to be completely beyond reproach, and  
3           in my sense they also have to be critics of the  
4           system.  If they're not a critic, if they're seen  
5           as part of it, then people will come back to them  
6           later on and use them, and say why didn't you,  
7           why didn't you, why didn't you, and why didn't  
8           you.  So why not bring them in to begin with, and  
9           then when you've got them in the tent you're  
10          going to have the benefit of their advice instead  
11          of their spears at a later date.

12           Those are my thoughts.

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

14           Again, let me ask if anyone on the Board has  
15          questions or items for clarification of Mr.  
16          Miller.

17           (No responses)

18           **DR. ZIEMER:**  Apparently not.  Thank you very  
19          much.

20           Are there any other members of the public  
21          that wish to make comments?

22           **MR. TABOR:**  I remembered the comment that I  
23          didn't make before, if you'll let me make that.

24           **DR. ZIEMER:**  Okay.  We'll count that as --

25           **MR. TABOR:**  I'll make it quickly, and I can

1 make it right from here.

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

3 **MR. TABOR:** At the last meeting I reminded  
4 the Board about record-keeping. I'd like to  
5 remind us again about record-keeping. We have a  
6 lot of sites out there that are closure sites,  
7 and records are going to be going away.

8 I was hoping that there was a way that the  
9 Board could possibly influence whatever other  
10 agencies or departments there are in government  
11 to possibly suggest to some of these sites to go  
12 back into a mode of record retention, because  
13 recently I believe there's been some -- what's  
14 the word I'm looking for -- release or  
15 legislation that says that record retention is --  
16 that's been lifted. I don't know if that's the  
17 exact words, but looking at not just the data  
18 you're going to be looking at but looking at some  
19 of the processes and the records on hand, the  
20 historical records of the operations of these  
21 sites, as well as the information from some of  
22 the old-timers, that's going to be very, very  
23 important in my mind.

24 And I really believe that, if there's a way  
25 that the Board has any influence to say to

1           whatever other agencies there are, that it might  
2           be beneficial to suggest that we not lose these  
3           records. Some of these sites are still going to  
4           be here for a long time, but Fernald is not. I  
5           just wanted to remind you about that, folks.

6           That was my fourth item that I didn't think  
7           of up there. Thank you.

8           **DR. ZIEMER:** Thank you.

9           We actually have at our disposal  
10          approximately an hour, and I'm wondering if the  
11          committee has enough -- the committee, the Board  
12          has enough stamina to use that hour as -- to do  
13          some of the evening work that's before you. We  
14          can leave it at your option.

15          But for example, Mark, if your group would  
16          rather do some work now rather than wait till  
17          after dinner, and likewise for our other group.  
18          So I'm going to suggest that we just recess from  
19          the formal meeting, allow the little  
20          subcommittees that need to work to stay and do  
21          their work. Others can take a break. But I  
22          think we can stay here and use the room. Is that  
23          agreeable to everyone? It might be a little more  
24          efficient if you do that work now rather than  
25          wait until after a big dinner and a few drinks

1 and what all.

2 (Affirmative responses)

3 **DR. ZIEMER:** In that case we'll recess from  
4 our formal meeting and go to our working groups.

5 (Whereupon, the meeting was adjourned at  
6 4:19 p.m.)

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C E R T I F I C A T E

STATE OF GEORGIA )  
 )  
 COUNTY OF DEKALB )

I, KIM S. NEWSOM, being a Certified Court Reporter in and for the State of Georgia, do hereby certify that the foregoing transcript, consisting of 270 pages, 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 22<sup>nd</sup> day of July, 2002.

\_\_\_\_\_  
 KIM S. NEWSOM, CCR-CVR  
 CCR No. B-1642

[SEAL]