**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

TWENTY-FIFTH MEETING

**ADVISORY BOARD ON**

**RADIATION AND WORKER HEALTH**

**VOL. I**

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at the Hyatt Regency Buffalo, Two Fountain Plaza, Buffalo, New York, on June 2, 2004.

# C O N T E N T S

June 2, 2004

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# PARTICIPANTS

(By Group, in Alphabetical Order)

## BOARD MEMBERS

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

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

MEMBERSHIP

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

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

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

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

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

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

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

OWENS, Charles Leon
President
Paper, Allied-Industrial, Chemical, and Energy
Union
Local 5-550
Paducah, Kentucky

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

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

AGENDA SPEAKERS

(in order of appearance)

Dr. Jim Neton, NIOSH

Ms. Roberta Mosier, DOL

Mr. Grady Calhoun, NIOSH

Mr. John Condray, OGC

Dr. Richard Toohey, ORAU

Mr. Ted Katz, NIOSH

Dr. Jim Neton, NIOSH

Dr. Paul Ziemer, Chair

STAFF/VENDORS

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

AUDIENCE PARTICIPANTS

ALLEMAN, STEPHANIE
BARTOSYEK, J.
BURGESS, LINDA
BUSH, MAUREEN A.
COLVIN, KAREN
DEHART, JULIA
DIMITROFF, JOHN
DIRENZO, GAYLE
DOOLEY, DAVE
ESPINOSA, KEVIN
ESTOFF, C.W.
FIGIEL, J.
GIBSON, DYLAN
GIBSON, JILLIAN
HEISTER, MELANIE
HENSHAW, RUSS
KATZ, TED
KOCHANSKI, JOHN J.
KOCHANSKI, ROSE P.
KOCHER, DAVID C.
KOTSCH, JEFF
KRAWGGEL, WALTER & PATRICIA
LAWRENCE, DAVID
LIVINGSTON, CYNTHIA D.
LIVINGSTON, JEROME
MAURO, JOHN
MCCARTHY, MARY
MELLODY, CINDY
MORT, DOROTHEA I.
MORT, JANICE
MOSIER, ROBERTA
NAIMON, DAVID
OWENS, ELSIE
PANASUK, FRANK J.
PRINDLE, ANNETTE
ROBERTSON-DEMEIRS, KATHRYN
SCHRAEDER, JANE
SWEENEY, THERESA
TENFORDE, THOMAS S.
TITUS, LIZ
TOOHEY, DICK
VONDERALE, NANCY J.
WALKER, EDWIN C.
WALKER, JOYCE A.
WESNIEUSKI, THOMAS

PUBLIC COMMENT

BARTOSYEK, JANICE
BURGESS, LINDA
ESPINOSA, KEVIN
KOCHANSKI, JOHN
KRIEGER, RALPH N.
LAWRENCE, DAVID
LIVINGSTON, JEROME
O'BRIEN, EUGENE J.
OWENS, ELSIE
STOCKWELL, FRED
WALKER, ED

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

(9:00 a.m.)

**REGISTRATION AND WELCOME**

**DR. ZIEMER:** Good morning, everyone. and welcome to the 25th meeting of the Advisory Board on Radiation and Worker Health. My name is Paul Ziemer. I serve as Chair of this particular Board. The record will show that all of the Board members are present, with the exception of Dr. Henry Anderson, who is not able to be here today, and Wanda Munn, who will be joining us. She was delayed by weather en route, but hopefully will arrive here mid-morning.

We remind you, and if you don't already know it, that we want you to register your attendance with us. This includes all present -- Board members, visitors, staffers. Register your attendance at the table near the entrance in the registration book. Also if you're a member of the public and wish to address the Board during the public participation period, we ask that you let us know that so that we can schedule the timing on those remarks, and there's a

separate registration book for you to indicate your interest in making public comment.

On the table -- where's the table? There's a table somewhere -- oh, way in the back -- with a lot of documents on it. That includes copies of today's agenda, copies of a variety of documents, some from previous meetings, things like minutes or summaries of various presentations. Those are on the -- are on that table in the back, as well as some presentations that will be made today.

We have several special guests with us this morning that I would like to introduce -- in random order, not playing any favorites here. Jane Schraeder, who is here representing Congressman Slaughter's office -- Congressional office; Thomas Wesnieuski, who's here representing Congressman Jack Quinn's office -- indicate who you are; and also C.S. -- C. W. Estoff -- C. W. Estoff, also representing Congressman Quinn's office; and then Cecilia -- you know, I can't read my own writing -- is it Lerner?

**MS. LIMA:** Lima.

**DR. ZIEMER:** -- Lima, representing Senator Hillary Clinton's office. Thank you all for being with us today. We appreciate having you in attendance here.

We have a very full agenda. That agenda includes a public session this evening, so I call that to your attention. If there are members of the public here who do wish to address the Board and find that you will not be able to be here this evening, we will try to make opportunity late in the afternoon for you to make remarks to the Board, but that will depend a bit on how the schedule goes. The agenda, as it's been distributed, is what we will follow. The times are not necessarily times certain. We may get ahead, we may get behind a little bit and may have to adjust. But the evening session of course is a time-certain session, so we hope many of you will be back here for that evening session and the public comment period.

Now I also would like to introduce our representative from NIOSH who is our Federal officer on the Board, and that is Larry

Elliott. Larry, you may make a few remarks here, also.

**MR. ELLIOTT:** Thank you, Dr. Ziemer. On behalf of Secretary Thompson from the Department of Health and Human Services and Dr. John Howard, the director of NIOSH, I'd like to welcome the Board to Buffalo. It's been a short month since myself and a few others were here last in May, and we look forward to a productive meeting. As Dr. Ziemer indicated, we do have a full agenda with a lot of information to exchange here today and tomorrow, and we hope that the public finds this Board meeting an informative and a beneficial experience. Thank you.

**DR. ZIEMER:** And for Jane Schraeder, I had a senior moment and I realized that Congress -- Congressman is really Congresswoman Slaughter, so let the record show that the Chair finally woke up on that.

**MS. SCHRAEDER:** Thank you.

**DR. ZIEMER:** Thank you.

**MS. SCHRAEDER:** She thanks you.

**REVIEW AND APPROVAL OF DRAFT MINUTES, MEETING 23**

**DR. ZIEMER:** The minutes for meeting 23, which -- which meeting is dated April 20/21, 2004, the meeting held in Richland, Washington -- the minutes are -- they take longer to read than the actual meeting took, but they -- there's 68 pages of minutes. I believe most of the Board members got these in advance, though, did you not? You did not? I thought these had been distributed by e-mail.

**MS. HOMER:** They have.

**DR. ZIEMER:** Most of them don't want to admit that they got them in advance. I do want to ask the Board if you are ready to act on the minutes, if you are -- if most of you are not, we can delay this till tomorrow so that you have an exciting evening ahead here in Buffalo. Are there Board members who wish to delay the action on the minutes? Apparently not -- oh, Roy DeHart.

**DR. DEHART:** I would prefer if we did. I only saw these for the first time yesterday.

**DR. ZIEMER:** Use your mike there, Roy.

**DR. DEHART:** I only had the opportunity

to see these yesterday and I did not get through them all because there's some other materials I wanted to read in the book, as well.

**DR. ZIEMER:** Okay. Is there any objection in delaying the action on the minutes?

(No responses)

**DR. ZIEMER:** There appears to be no objection, so without objection we will delay action on those minutes until tomorrow's session. And I'll remind you again, if you have minor typos and grammatical errors and dangling participles, you can turn those in directly to me or to Cori, and we'll get those corrections made. We will be looking for substantive corrections in the minutes then tomorrow. Thank you very much.

I also want to point out to the Board that the 24th meeting was the telephone meeting that we held -- I forget the exact dates, but it was just a couple of weeks ago. The minutes of that meeting simply consist of a statement that we met and what

the topic was, which was the -- I don't mean telephone meeting. I mean the Cincinnati meeting. I stand corrected. It was a face-to-face meeting in Cincinnati where we did the independent cost estimate for our contractor's task. And the minutes of that type of meeting simply state that we met and that we -- and what the topic was, which was the independent cost estimate, so it's a basically one-line minute and I have approved those on behalf of the Board. Without objection, we'll take it that those minutes are approved.

Dr. Neton is going to bring the program status report to us this morning. Jim, we welcome you to the podium.

**PROGRAM STATUS REPORT**

**DR. NETON:** I don't know if it's -- I can't tell if it's working or not. Can everybody hear me all right?

**UNIDENTIFIED:** Yes.

**DR. NETON:** All right, good. It's my pleasure to be here today to go over our progress and accomplishments since the last Board meeting we had in Richland, Washington

I think on April 20th, was the last time we met. So I'm going to go over some of the basic statistics and accomplishments that we've performed since the last meeting.

We continue to receive cases from the Department of Labor. As you can see from the slide, about two-thirds of our cases are still represented by the two district offices combined, from Seattle and Jacksonville. We're at about 16,500 cases in total received from the Department of Labor. That's not in our possession. That's the total number that we've received from the inception of the program. I think this represents about a 400 net -- a 400 case increase since the last Board meeting.

As you can see, as in the last Board meeting, the number of cases continues to come in at around 200, 250 per week -- or per month. This last quarter is missing June, so when that comes in I think we'll still be right around the 800 for the quarter coming in.

We continue to send out requests to the Department of Energy for exposure

information for the cases as they arrive at NIOSH. We've sent out requests for 14,000 -- about 14,348 cases. That number is lower than the 16,000 cases we've received. I might remind you because we do not send exposure requests for claims from many of the Atomic Weapons Employer establishments. There is no clearinghouse for information at those sites. We rely on going to individual records repositories to try to retrieve information for those facilities.

And we've received responses for 13,400 cases from the Department of Energy. Now that means we've received a response. It doesn't mean that the response we received, again, is complete and sufficient to do a dose reconstruction. An adequate response or not -- a response from the Department of Labor could just -- or Department of Energy could be we have no information; we've looked through our files, we have no monitoring information for that individual.

We keep track of the age of outstanding requests. The number is quite low considering that we've sent out 14,000

requests. Nonetheless, we are working diligently to try to work with the Department of Energy to reduce that backlog of outstanding requests. And Grady Calhoun, later on in the session, is going to talk about what we've been doing in that area in regards to our report to Congress on our ability to information from the Department of Energy.

Telephone interview statistics continue to increase, 14,400 cases for which one interview has been completed for each case. Again, I remind you that -- well, it's -- one interview has been completed so that there are multiple claimants per case, so oftenti-- so it's hard -- it's difficult to track completed interviews. We've done 19,177 individual interviews, since there are multiple claimants per -- per case. The capacity still is in place to do 200 to 300 interviews per week, and that's going along quite well.

This graph shows the number of interviews conducted by month, and you can see they stabilize anywhere from 1,100 to

1,200 interviews per month. This is not the rate-limiting step in this process. We feel this is going along fairly well. Dr. Toohey from Oak Ridge Associated Universities will talk later today about the interview process and in particular discuss some of the quality assurance/quality control issues related to the interviews.

Cases staged for dose reconstruction is around 5,000 at this point. That means that we've received a response from the Department of Energy, we've looked at the Department of Labor referral, the information there appears to be correct and a profile is in place or some other mechanism is there for us to determine that the case could be ready to go for dose reconstruction. And in fact, this really represents the number of interview -- the number of dose reconstruction contact letters that have been sent out to claimants. That is, a claimant receives a letter that says we're ready to start; here are the potential individuals who could be doing your dose reconstruction; do you have

any perceived or real conflict of interest with those people doing your dose reconstruction.

1,082 have been assigned, that means are actively in the process. They're being worked by health physicists at this time. Right now -- this is not on here, but we have a -- an inventory right now seems to be stabilized at about 400 to 500 OCAS-1 forms in the hands of claimants. That's sort of our potential pool of claims that can be turned back to Department of Labor. Soon as the OCAS-1 form is signed, we turn those around and submit those to the Department of Labor. We have to get all the OCAS-1 forms for each case because each case could have multiple claimants.

We've sent out over 3,000 -- 3,400 draft reports to claimants. Those are individual dose reconstructions that have been completed, and we're very close to 3,000 final dose reconstruction reports sent to the Department of Labor for final adjudication. I was hoping that this could get to 3,000. I just got an e-mail this

morning that said we're very close, but we're not quite at 3,000. So as you might realize or recognize, the time to get to the next 1,000 block has substantially decreased in recent times. It took us quite a while to get to 1,000, less time to get to 2,000, and we'll get to 3,000 in fairly short order.

This represents just the number of dose reconstruction reports by month that we've sent to claimants. We've had a record month in May where we've sent out 480 dose reconstruction reports, still short of the goal of 200 per week on average. I think last week we had a record week, as well, where we sent out 144 draft reports to claimants. So we are making a tremendous improvement in this area and we hope to get to our goal of 200 in short order.

I might point out over the last three months we've done in excess of 400, and we're fairly optimistic this number will increase in the next several months.

As I discussed last time, the dose reconstruction final reports to claimants

tracks very closely the number of drafts we have, and this is really just the number of OCAS-1s that we've got from the drafts. In other words, has the person -- the claimant reviewed the dose reconstruction report, understood it and signed the OCAS-1 form indicating that they have no additional information to provide at this time. And so last month, again, we had a record shipment of final reports to Department of Labor at 409.

Last time -- the last Board meeting was the first time we'd presented this slide, which is the cases completed by tracking number. I'll remind you that this is the NIOSH tracking number that goes from zero to 16,000. Each case that we receive from the Department of Labor is assigned a sequential number from one to over 16,000. So this is the number of cases that we've completed per block of 1,000 tracking numbers, these being the earliest cases that we have received, the idea being that we want to emphasize and process these cases quicker than these because these cases have been in-house much

longer. In practicality that's not possible because many cases have complex twists and variations and different work histories so that some of these earlier cases can be processed much quicker -- people with very short employment duration, some -- some cancer types that are fairly non-radiogenic that we can be claimant-favorable with the dose reconstruction. So we do process these. If we can get an answer to the claimant in a fairly short order without doing additional research, we will do it. And that's what's represented by these claims in here.

We are working on getting more emphasis placed on these cases. ORAU -- Oak Ridge Associated Universities -- has realigned their process, as we discussed last time, into two teams, Team A and B. Team B is targeted with doing the more difficult claims, claims that take more than a day or so, once all the information is in place. And the reality is that those represent more of the internal dosimetry -- the people would have more difficult or detailed

internal dosimetry exposures that are more complicated to perform. I think as Team B ramps up and becomes more facile with what they're doing, we'll start to see a decrease in this area, and we're certainly targeting that process.

Submittals versus production, again, we're putting out about 400 a month at this point. And so for the last three months or so we've outstripped the shipments from the Department of Labor. We're making a dent in the backlog, albeit it small. I think we've reduced it by a couple of hundred claims last month, but it's at least rewarding to get -- you know, to be more than treading water, starting to swim a little bit. And again, we hope that this line continues. We of course can't control the blue line, which is shipments from the Department of Labor. If there is a large spike, for whatever reason, in claims, you know, this will be more difficult to maintain. But nonetheless, we are starting to reduce the backlog.

Administratively closed, the dose

reconstructions -- our regulation allows us to close a dose reconstruction if we have not received an OCAS-1 form within 60 days of receipt -- within 60 days of the claimant receiving the dose reconstruction report and they have not provided any additional information. So out of the 3,000 or so cases that we've done, there's a few that have reached that stage and it's staying fairly consistent I think. This is 24 cases so far out of 3,400 that we've done where the claimants have not signed the OCAS-1 and we sent out a letter indicating that the dose reconstruction is closed.

Now that doesn't mean the case is closed. We notify Department of Labor that we are administratively closing the dose reconstruction, and the Department of Labor has the option to administratively close the claim -- or the case. I'd like -- I might add here that when we close a dose reconstruction, I mean really it just gets suspended. It's taken off of our tracking list. If a claimant provides additional information or signs the OCAS-1, there is a

mechanism for that case to be reopened.

Amount of rework, this represents the number of claims -- of cases that have been returned to us from the Department of Labor for reanalysis. The number appears to be tracking up, but this basically represents the increase in our workload. It's staying fairly constant. It's somewhere -- it's difficult to track the exact rate, but I'd say it's somewhere in the six to eight percent range. There's always a lag time between when we send out the cases for final adjudication till when Labor goes through the final adjudication process and makes a determination we need to do more work. Oftentimes that involves additional communication with the claimant. Many -- many, if not most, of these reworks are due to additional information from the claimant after we've processed the dose reconstruction. That could be the addition of another cancer that wasn't claimed on the original claim, the work history, the work period had changed slightly or been verified since we received the claim, the date of

cancer diagnosis oftentimes ends up moving a little bit so they'll come back to us, the Department of Labor, and we'll rework them. We have a goal of reworking these -- we did have -- early on a goal of turning these back around within 60 days. That was when the adjustments were fairly small. If they move the date of diagnosis of cancer a week or so, it was fairly simple for us to re-run the dose reconstruction to accommodate that. But when they come back with additional cancers -- for instance, if we've used the efficiency process and the primary cancer was prostate, we may take a whole different approach for that dose reconstruction than if it comes back and says the primary cancer was bladder or lung or liver cancer. That would almost require us -- not exactly back to square one, but to start very back in the process. And it's been difficult for us to move some of these through in that -- in those cases within a 60-day window. So we do our best to get these back, but you know, sometimes it's just not possible.

The phone calls continue to increase.

Again, we've got over 30,000 phone calls in to OCAS. I think since the last Board meeting we've received 1,000 additional phone calls from this statistic. ORAU has gone from 84,000 to 94,000, so they've handled 10,000 phone calls since the last Board meeting. That includes all the scheduling and set-up that ORAU does, but it's still a large number of claimant contact going on with ORAU. And the number of e-mails has increased to 4,440, up 500 since the last Board meeting.

Recent accomplishments, published 42 CFR 83, the SEC procedures that are out there as of last Friday. I know Ted Katz will be giving a presentation later today on that subject.

Physicians panels continue. We've appointed over 200 physicians to the panels, working with the Congress of Occupational Environmental Medicine and other groups to identify additional candidates. I know in the next week or so we're planning on sending over 20 additional names to work on the panels.

We've been doing a lot of worker outreach -- worker and claimant outreach. We had a dose reconstruction workshop in Cincinnati on the 25th and 26th where we invited -- I think I announced it at the last -- announced this at the last Board meeting. We invited health and safety labor representatives from around the country, as well as some special interest group people, to Cincinnati to go over the dose reconstruction process, sort of from soup to nuts, to go over the regulation, the probability of causation calculations and dose reconstruction. We ended up having about I think 34 people at this meeting, and I heard very good positive feedback from this. I think it went very well. We went a long way towards getting these folks understanding what we're doing. I don't know that everybody still agrees with what we're doing, but at least there's a mutual understanding of what we're doing and why. We may end up having additional workshops in the future as the need arises.

We also had on May 4th a meeting out

here in Buffalo with Bethlehem Steel stakeholders. We had two separate meetings, one with, again, some special interest groups in the afternoon, about a three-hour meeting. That went fairly well. And then we held an evening town hall session with a couple hundred attendees, and we think we did -- we did very well communicating with those folks as to what we've done, why the dose reconstructions are done the way they were and why the probability of causations were coming out the way they are. So I think these were two very successful claimant-contact sessions that we've had.

Just recently, within -- I think yesterday -- the IMBA analysis request feature has been added to our web site. I call this Ask IMBA. That's not what it's officially called, but claimants, stakeholders, interested parties can send us an e-mail request or a request in writing to have an IMBA analysis done. For those of you who aren't aware, IMBA is our Integrated Modules for Bioassay Analysis program that does the internal dose calculations for our

cases. So one can ask for an IMBA analysis for hypothetical exposure scenarios, scenarios that are outlined in our site profiles, so that one can get a feel for what the doses are for certain inhalation and ingestion exposures.

One thing that's not on here that I'm going to talk about later on in the status is we have modified the Bethlehem Steel site profile to accommodate the ingestion pathway, and I'll be getting into that in some detail after lunch.

I think with that, that finishes my formal remarks. I'd be happy to answer any questions, if there are any.

**DR. ZIEMER:** Thank you, Jim. Let's open the floor now for questions. Jim Melius.

**DR. MELIUS:** Yeah, I got -- I have several questions. First, the -- the -- what is the backlog? I don't think you actually presented the number there.

**DR. NETON:** The backlog of cases that we have that -- 16,400 is what we received. You're asking how many we have right now in

our possession.

**DR. MELIUS:** Right now.

**DR. NETON:** I don't have that statistic available, but I would suspect it's somewhere in the high 15,000's, and we've been reducing the backlog -- again, it depends on what you mean by backlog, but of cases we've received from Department of Labor, we probably have about 15,600 or 700, I would guess. We're reducing it by a couple of hundred every -- every month.

**DR. MELIUS:** Yeah, that was the point I was trying to understand. I mean I'm trying to understand what your defin-- you kept referring to backlog and --

**DR. NETON:** Yeah.

**DR. MELIUS:** -- trying to 'stand 'cause if I understand the numbers you were presenting, you're running about -- at the present rate, about 200 to 250 cases ahead -- per month ahead of the number that you're receiving from the Department of Labor, so you know, that breaks out to, you know, 3,000 per year, which tells me that it's another five years to get --

**DR. NETON:** Right.

**DR. MELIUS:** -- the backlog and that's making a lot of assumptions, but it's still...

**DR. NETON:** Right. Well, again, we hope to get to 200, which would -- I think you'd get to somewhere around 7,200 -- you know, a net decrease in a year.

**DR. MELIUS:** Yeah.

**DR. NETON:** But then you have to define what do you mean by a case that's in backlog, what -- you know, what is the -- where do we want to be -- what's -- where do we want to be with the average age of a claim in our possession or a case in our possession. I think it's unrealistic to assume that there will be a zero backlog. I mean there's going to be a certain period, and frankly we had not really defined that just yet as to what is the optimal, you know, age of a claim, I suppose, if you want to put it that way.

**DR. MELIUS:** Yeah, well -- but it should be possible -- I mean should have enough information to be able to estimate

that.

Then the other question I have is -- I'm just trying to get a better understanding of what you're doing. And with those early cases, the -- you know, the first 1,000 or whatever, you've done 300 of them, I think, roughly, was what you presented.

**DR. NETON:** Well, out of the first -- yeah, the first 1,000, right.

**DR. MELIUS:** First -- first 1,000.

**DR. NETON:** That's right.

**DR. MELIUS:** Of those that are left, this -- the 700 that are left, how many of those aren't completed because the -- a site profile's not completed yet and how many of them are, you know, difficult cases in the --

**DR. NETON:** I can't speak to that specifically, but I think a large number of those are due to site profiles. I'll be talking about where we are with site profiles later. I think we have about -- site profiles that cover about 50 percent of the claimant population that we have in-

house.

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

**DR. NETON:** And if one makes the assumption that the mix in that first 1,000 is representative of all sites, then it would be about half of those don't have a site profile. That -- that would probably be fairly accurate.

But the other issue is the site profiles right now do not really adequately address unmonitored workers, and that's something that we're working on very diligently right now. How do you address -- you can have a site profile that interprets all the bioassay and the TLD measurements and talks about the source term, but when you have a worker who was unmonitored at all, you have to make some distinctions of whether they should have been monitored; didn't need to be monitored; and if they weren't, what those exposure situations were. And we're working very -- very hard right now on establishing the coworker database that will help move those forward.

**DR. MELIUS:** Okay, but -- but then --

so you have like three categories in -- in that 700 cases, you're telling me. You have site profiles haven't been completed. You have some that have complicated exposure histories 'cause, you know, internal doses and -- and so forth, but you have a site profile. It's --

**DR. NETON:** Right.

**DR. MELIUS:** -- just a question of the amount of effort it may take. And third, you have these difficult cases because there's not personal information on -- on their exposure so they take more -- do it, and I guess what I keep getting concerned is that as you, you know, sort of -- you're doing the -- and I -- well, first of all, I think you're taking some good steps. This A and B team I think -- think makes sense, but you're still leaving a lot of people, you know, who've been waiting around for what, three years or whatever it is, in that group that -- I'm not sure they'll ev-- you know, you'll ever get to them or when you'll get to them, I guess is a better -- I'm sure you'll get to them, but -- and you know, is

there a process to sort of go through and sort of figure out, among those early cases, what -- where you need to put resources 'cause at some point -- I mean if those people stay in the backlog forever, you know, that's obviously not what you want or anybody wants and -- and it's a question of resources or -- or a question of -- I mean are these people for a Special Exposure Cohorts, where -- how does that all -- you know, how are we going to handle all those cases?

**DR. NETON:** Okay. Those are some very good questions, and I don't have a really good answer -- you know, an answer to, but at some point you're right, our regulation allows us to say we can't do a dose reconstruction, and at some point we may get there.

**DR. ZIEMER:** Larry Elliott.

**MR. ELLIOTT:** I would add also there -- I think there are many flavors in that first 1,000 block and the second 1,000 block, perhaps even in the third 1,000 block. One of those flavors is AWEs and -- and some of

those cases in that first 1,000 block that are representative in an AWE we don't have a site profile or exposure model, or maybe we haven't even found whether or not there's any information for that particular AWE, we're still searching.

Secondly, I would add as a point of clarification that we are concentrating our efforts on looking at those first 1,000 block cases, the second 1,000 block cases, and we are concerned about moving them through the system as quickly as possible, realizing that they've been there for three years. And so there's a screening process that ORAU applies to that.

There's also within OCAS the public health advisors who are the champions of the claimants, have been going through and identifying claims which have an Energy employee still alive associated with it. We think that's another targeted area that we need to concentrate on. If the Energy employee is still alive, we're making sure that we capture their interview before they're lost to us, at the very least. And

then we're having health physicists look at the case to see if they can move it in any way, shape or form under the many tools that are available to us.

So there's a concerted effort, I think, looking at these in that light and trying to move them through.

Additionally, now that we have our SEC rule, we've added emphasis to looking for cases that can't be reconstructed.

**DR. MELIUS:** I just think it might be helpful to do some analysis of that and actually put some numbers -- you know, in sort of figuring out where your priorities need to be and how -- how to handle those cases. That's, I think -- I think the point. I think you're probably moving in the right direction. It's just a question of what's the right mix of resources to apply for that -- apply to those cases.

**DR. NETON:** You're exactly right. Some of the site profiles we're working on have some problematic areas that we need to look at. And if we can't do the site profile, then almost by definition we're not going to

be able to do certain pieces.

**DR. MELIUS:** So then the question is then -- you know, you put those on hold, go and improve the site profile, if that's possible -- I mean for that area or something we need to do...

**DR. ZIEMER:** Thanks. Other questions or comments?

**DR. MELIUS:** I have some more --

**DR. ZIEMER:** Yeah, well, let --

**DR. MELIUS:** -- if nobody else does. I don't...

**DR. ZIEMER:** Let me ask one at this point. On your reference to the e-mail inquiries, can you characterize those -- are they in any way different than the phone inquiries, or is there -- what -- these 4,440 claimant e-mails, how would you characterize what -- what's the nature, or is there a pattern to those?

**DR. NETON:** Well, it may be better or -- Chris Ellison, who --

**MR. ELLIOTT:** I think if Chris would come to the mike, she can speak more competently about the variety of requests we

get by e-mail. Chris Ellison is our health communications specialist in OCAS and many of the people in the public here may have interacted with her or one of our public health advisors.

**MS. ELLISON:** Good morning. Most of the e-mails follow the phone conversations. A lot of the e-mails come in inquiring about the status of a case. At times they're a program question. It's a wide variety, and at times there are FOIA requests that come via the e-mail. It's a general nature of that sort.

**MR. ELLIOTT:** Congressionals?

**MS. ELLISON:** Congressionals, we do get Congressionals through the -- the e-mail system, and -- I'm trying to think if there were any other -- it's primarily the status, from the Congressionals and from the claimants, and then of course the FOIA requests for records. You see a lot of those come through. And even -- we get -- receive the CVs from the physicians to be nominated for the physician panels come through the OCAS inbox.

**DR. ZIEMER:** Yeah, I was only talking about the claimant e-mails, however.

**MS. ELLISON:** Right. And when we count those, a lot of that comes in -- it's a miscellaneous category -- that gets counted.

**DR. ZIEMER:** Okay, thanks.

**MS. ELLISON:** Okay.

**DR. ZIEMER:** Others? Okay, Leon and then back to Jim.

**MR. OWENS:** Dr. Neton, in regard to the administratively closed records, I realize there's a very small number of cases there, but is there a letter that accompanies, once the record is closed?

**DR. NETON:** Yes. Yeah, the claimant is sent a letter saying that we're administratively closing the dose reconstruction and notifying the Department of Labor as such.

**MR. OWENS:** Is there a -- can you give us, again, a flavor from the standpoint of -- of these cases? I mean are we talking about elderly people who may not fully understand the process or is there information that is not adequate from the

standpoint of their records?

**DR. NETON:** It's not an adequacy of the records issue. I mean we -- you know, we've done the dose reconstruction. We believe we've done a fair estimate of their dose. Why people don't sign the OCAS-1, I really can't -- I can't speak to. You know, we have several points of contact with the claimant. We call them. Oak Ridge Associated Universities closes out the dose reconstruction, contacts them, asks them if they have any questions about the dose reconstruction, do they have any additional information to provide. For whatever reason, certain people just are reluctant to sign the form.

**MR. ELLIOTT:** If I might add to this, the 24 that you saw there I think are representative of cases that would have received a denial from the Department of Labor. There were two cases that were presented in that slide I think in an earlier session of the Board that represented compensable cases and we've cleaned those up. We've got back to the

claimant and explained what was going on with their particular situation and encouraged them to complete the process, and they did. So to further provide some clarification here, the -- once the draft dose reconstruction report, along with the OCAS-1 form, is mailed to the claimant, there is a follow-up closeout interview that is done. And that interview is offered to hear any concerns or complaints the claimant might have, also to help them understand the content of the dose reconstruction report, to answer any questions they may have in that regard, and to determine if they have any further information to provide or not, and then to encourage them if they don't to sign the OCAS-1 form. So each claimant gets a closeout interview, and we have seen some claimants that don't want to -- to avail themselves of that and we just -- from that point on, we seem to lose their interest, I guess. And so in this instance, we have 24.

Now at the 60-day mark, we're trying to be as compassionate as possible, and so we don't close it out immediately on the 60-day

mark, 60 days from the day we think they received it. We actually -- at that point we send another letter that we call the 74-day letter and we give them another two weeks' worth of time to consider this. We -- in some cases they follow up with another phone call to see if -- if there are any questions or issues that can be resolved over the phone. After the 74-day mark, then there's -- if there's no further contact, no indication that they have additional information that they're searching for, we administratively close the dose reconstruction.

If, however, they say well, I'm pursuing a line of inquiry. I think I can find more information or I'm looking for -- I think there was an additional diagnosis that wasn't accounted for in my original claim, then we allow them that time, whether -- we ask them what time do they think they need, and we keep it open.

**DR. ZIEMER:** Thank you. Jim Melius.

**DR. MELIUS:** Yeah, two questions. This is actually from prior meetings, status of

IMBA access for -- you know.

**MR. ELLIOTT:** Well, we are -- we're pleased that we get a help desk up on our web site. Your particular question I think is asking about IMBA for the Advisory Board and IMBA for your contractor, Sanford Cohen & Associates, and we are still working on the user's -- end user's license for both of those participants, the Board and your contractor, to get access to IMBA. We're still working with the vendor to put that into place.

**DR. MELIUS:** Any idea of when this will take place? I mean I don't -- I don't need to remind you, but --

**MR. ELLIOTT:** It's --

**DR. MELIUS:** -- this is sort of a rate-limiting step because of...

**MR. ELLIOTT:** You need it -- I understand you need it. We're working as hard as we can. I think it's imminent, but I can't promise that it's going to be here -- I won't promise it's here today or tomorrow. As soon as we can put it together.

I'm sure your next question is conflict of interest.

**DR. MELIUS:** No, I was going to save that for later, but if you want to answer that now, you're welcome to --

**MR. ELLIOTT:** I will, I'll just jump out here and do this because I know your -- your line of questioning. The conflict of interest on -- on site profile development and that policy is -- is still in review and being evaluated, and we hope to have it put together and done soon.

**DR. MELIUS:** But --

**MR. ELLIOTT:** That's all I can say on that. We're working diligently about that, as well.

**DR. MELIUS:** But you've already awarded more contracts. Is that true?

**MR. ELLIOTT:** Pardon me?

**DR. MELIUS:** You've already awarded more contracts or subcon-- whatever they are for doing more site profiles. Is that -- that's what I thought...

**MR. ELLIOTT:** Well, do we have more site profiles under development? Yes.

There is a policy that is being adhered to right now at ORAU that we agree with and we -- and has been articulated in previous Board meetings, and that is that -- and it's very similar to the conflict of interest policy for dose reconstructors, that they -- a person working on a site profile cannot be the principal author if they've had expertise in management of a dose reconst-- of a dose monitoring program at a -- at a given site -- at -- for the site where the site profile's being developed from.

**DR. NETON:** There are also provisions for organizational conflict of interest, as well. If the company --

**MR. ELLIOTT:** Right.

**DR. NETON:** -- had done a substantial -- any work at all related to dose reconstruction, dosimetry, radiation protection programs practices, they could not be working on that profile.

**DR. MELIUS:** I mean just -- needless to say, it's sort of absurd to have -- not have a policy and yet follow a policy and award contracts under it and -- does not generate

a lot of confidence in the process.

I have two questions that arise out of the minutes. One --

**DR. ZIEMER:** Would you like Larry to ask these next two questions?

**DR. MELIUS:** No, no, I don't think that's -- he's welcome to.

The -- one is, did we ever get the -- the memo we sent up to -- through Secretary Thompson to Department of Energy, I don't ever remember -- recall receiving a final copy of that.

**DR. ZIEMER:** That --

**DR. MELIUS:** I may have.

**DR. ZIEMER:** -- was sent and it may be in this -- is it in this packet?

**DR. MELIUS:** Okay. Okay.

**DR. ZIEMER:** It is there.

**DR. MELIUS:** And it has gone over to the Department of Energy?

**MR. ELLIOTT:** I don't know that it has made its way to the Department of Energy. It's on its way --

**DR. ZIEMER:** It had to go to Secretary Thompson's office.

**MR. ELLIOTT:** It's on its -- it had to go through Secretary Thompson's office. He had to sign off on it.

**DR. ZIEMER:** Let's make sure it's --

**MR. ELLIOTT:** I believe it is in here.

**DR. MELIUS:** The draft of it's in the minutes. I mean I saw it there as we adopted it. I didn't see it in that second package, but I just glanced through, so...

**DR. ZIEMER:** I believe it came out or was distributed in a FedEx package, Cori, was it not?

**MS. HOMER:** I didn't distribute that one -- not the one that went to Secretary Thompson.

**MR. ELLIOTT:** It has been signed and it has been submitted. Now where it's at in its wending its way to the Secretary of Energy, I'm not clear on, but we'll make sure that y'all get a copy --

**DR. MELIUS:** Okay.

**MR. ELLIOTT:** -- of what was sent. And I'll let you know when it reaches DOE.

**DR. MELIUS:** Okay. Thank you. And then the other issue that came up at the

last meeting was regarding the Congressional responses that -- I'm just asking for clarification. There was an issue as to whether Paul could share the drafts with the committee members prior to -- to sending the draft, and since you didn't, Paul, I assume that there was a --

**DR. ZIEMER:** No, I think -- I think we decided before we left the meeting that we wouldn't be able to do that and therefore we agreed on the content of that letter. We can double-check in the minutes exactly how --

**DR. MELIUS:** I don't think the minutes reflect that -- reflected that -- originally there -- as I recall was that we were going to check as to whether we could do that or not, and I think that's the way it says in the minutes, but I'm -- if someone -- I -- that's not an immediate -- there's no immediate need to clarify it. I'm just trying to follow-up and understand what we can and can't do. And I've no -- and I've no problem with the letters, but...

**DR. ZIEMER:** Okay. The letter to -- or

memo, it really was a memo to Spencer Abraham, Secretary of the Department of Energy, through Tommy Thompson, I signed that on May 4th.

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

**DR. ZIEMER:** And that -- the distribution list shows the Advisory Board on the distribution list, so --

**DR. ROESSLER:** It's in the minutes packet.

**DR. MELIUS:** I just don't recall ever -- I'm just --

**MR. ELLIOTT:** We'll make sure you get that.

**DR. MELIUS:** Yeah, just get it, it's not a big deal to me. The other one we can deal with in terms of when we do the minutes, but I just would like some clarification.

**DR. ZIEMER:** Thank you. Mark Griffon.

**MR. GRIFFON:** I just have a question back to the presentation, Jim. On your dose reconstruction statistics you mentioned final DR reports, 2,940. How many of those are available for the Board review, final

from DOL? Maybe that's a DOL question, but...

**DR. NETON:** That's a good question that I'm really not prepared to answer.

**MR. GRIFFON:** Okay.

**DR. NETON:** I would say it's at a minimum the number of cases that Russ Henshaw presented last Board meeting where he went over the individual cancer statistics, 'cause I think that presentation was based on ones that the Department of Labor has adjudicated. So --

**MR. GRIFFON:** And then your --

**DR. NETON:** -- it's at least half, but I can't give you a number.

**MR. GRIFFON:** And then much like Larry, you're reading my mind for my next question, which was I asked last meeting if Russ could provide a breakout of all the cases by cancer type by site, and I don't know if that information's available in any way for the Board.

**DR. NETON:** Yeah, we're still working on that. I know Russ has been working on that issue, but I don't know that we're

prepared to share it with the Board at this meeting.

**MR. GRIFFON:** Okay.

**MR. ELLIOTT:** We recog-- if I could, we recognize that -- that you need that latter, I think, to make -- have an understanding of what type of cancers are available in the system -- would be available at some point in time for your review.

**MR. GRIFFON:** Right.

**MR. ELLIOTT:** It's also something that we need to get from DOL as to how many cases have passed the final adjudication mark and would be --

**MR. GRIFFON:** Right.

**MR. ELLIOTT:** -- available for your review.

**MR. GRIFFON:** Yeah, two -- two-fold. I mean one is our general selection criteria, but the other -- for those immediate -- the subset that are ready, I was hoping at this meeting that we could make some progress in actually maybe selecting some cases just to initiate our review process, so -- but it sounds like --

**MR. ELLIOTT:** I think we'd have to know how many from DOL have passed that -- that threshold --

**MR. GRIFFON:** Right.

**MR. ELLIOTT:** -- and which ones they are so that we could give you a listing of those tracking numbers, those case numbers and other -- whatever other demographic you want about a given case for your selection.

**DR. NETON:** And if I recall, this was by site, not just general numbers. Right? By the sites that you are --

**MR. GRIFFON:** Yeah, I was --

**DR. NETON:** -- targeting.

**MR. GRIFFON:** -- hoping to have by site, by cancer type by site, yes.

**DR. ZIEMER:** Yeah, that request is in the minutes --

**MR. GRIFFON:** Right.

**DR. ZIEMER:** -- in that discussion. Jim?

**DR. MELIUS:** Can I just go back to my question on the Congressional letters? On page 61 and 62 of the minutes there's reference to that and it really doesn't

clarify it -- said you were going to check with FACA as to what the procedure would be, so...

**MR. ELLIOTT:** I'm sorry, what page again?

**DR. MELIUS:** 61 and 62. We -- we passed a motion and then Larry, according to the minutes, you raised the issue of whether or not it was appropriate for the committee members to review the letter, and you were going to check with FACA. I mean that's the way it's -- the way I read it.

**MR. ELLIOTT:** Well, we'll --

**DR. MELIUS:** Yeah, and I would -- I guess I would like FACA clarification 'cause there's a -- states in the minutes that other -- similar committees I've served on, we've routinely reviewed letters that the chair has -- you know, drafted and I -- again, I don't object to the letter, I'm just trying to understand the procedure, and it's certainly possible, those other committees, we could have been operating incorrectly, but --

**MR. ELLIOTT:** I've let this one slip

through the cracks and I'll have to get a reading on it -- on the FACA-related aspect of it. And I'm sorry, I haven't done that yet. The issue, as I see it, is, you know, the public transparency process of coming to a decision and how that's done.

**DR. MELIUS:** I understand.

**MR. ELLIOTT:** So if -- if we can do it by e-mail and discuss it at a meeting and -- you know, we'll just have to look into that.

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

**MR. ELLIOTT:** So let me get back to you.

**DR. ZIEMER:** I think I left the meeting under the impression that we could not do that --

**DR. MELIUS:** Okay.

**DR. ZIEMER:** -- it clearly wasn't resolved at the meeting, yes, thanks. In any event --

**DR. MELIUS:** Again, I'm not objecting to the letter or anything. I'm just trying to understand for future reference.

**DR. ZIEMER:** Right. Thank you. Other questions for Jim Neton? Comments? Input?

(No responses)

**DR. ZIEMER:** Okay. Thank you very much, Jim. We're now scheduled for a brief break, so we'll recess for 15 minutes.

(Whereupon, a recess was taken.)

**DR. ZIEMER:** I'd like to call us back to order, please.

Before I introduce our next speaker, let me request that if you have a cell phone that you put it on the silence or buzzer mode -- appreciate if you would do that, please.

Also before the next speaker, I think Larry Elliott has some information on this FACA issue as far as circulating the letters in advance.

**MR. ELLIOTT:** My apologies on the sidebar here. Cori has quickly gotten me an answer on this FACA-related question about generating correspondence, and the answer as I understand it is as long as the Board decides that a correspondence letter needs to be generated, let's say, and determines the purpose for that and the focus in a public setting, you can -- and that decision

is on the table in front of the public, you can then draft your letter outside the public forum, share it by e-mail or however you wish, get input back from the individual Board members and finalize the letter without doing so in front of the public, as long as you don't stray from the agreed-upon purpose, intent and focus of the letter. Okay?

**DR. ZIEMER:** And may make the final copy available at the next --

**MR. ELLIOTT:** And I believe that's what happened at the last meeting on these -- on the letter in question right now. I think --

**DR. ZIEMER:** Well --

**MR. ELLIOTT:** -- there was discussion about doing the letter and what you wanted to see in the letter, but you didn't see the final.

**DR. ZIEMER:** Didn't circulate it before it was sent out, right.

**DR. MELIUS:** In fact our motion says that it was going to circulate and that's why --

**DR. ZIEMER:** My apologies.

**DR. MELIUS:** No, that -- again, I -- again, I've no objection to the letter. I was just trying to --

**DR. ZIEMER:** Thank you.

**DR. MELIUS:** -- unders...

**STATUS AND OUTREACH -- DEPARTMENT OF LABOR**

**DR. ZIEMER:** Next we'll have a status report from Department of Labor, and the presenter today is Roberta Mosier. Roberta is here -- there she is, thank you, Roberta.

Roberta's the deputy director of that part of the program. Thank you.

**MS. MOSIER:** Good morning, everyone. This is my first Advisory Board meeting and so this is a new experience for me. I'm thank-- appreciate the opportunity to come here today.

I have an update on our program. Some of the statistics will look very familiar to you. They're similar to what we have presented in the past.

To date we've received over 54,000 claims and of those over 38,000 were cancer claims, which represents about 70 percent of

the total claims that we have received. And you can see there also the numbers for some of the other categories. Beryllium sensitivity is about 4.4 percent, chronic beryllium disease claims is about 6.1 percent. Two percent of the claims are for silicosis, 11 percent of the claims are the Radiation Exposure Compensation Act claims on which we pay a supplemental benefit. And then we have a very large category of other. These are mostly non-covered conditions. It's 49 percent. And some of these categories overlap, so it adds up to more than 100 percent overall. Some people claim cancer and they claim heart disease, so you have some overlap there.

This slide represents the overall case status of -- and this is cases, as opposed to claims. You've probably heard this spiel before, but let me just say some of these statistics are presented in terms of claims, where it makes sense. Some are presented in terms of cases. And the difference is that you only have one case per covered employee. But if an employee is -- has died and they

have more than one survivor, you may have several claims because there are several survivors, so we have -- the claims numbers are always going to be higher than the case numbers.

But here you see the overall case status, the total number of cases -- the first slide was claims, which was 54,000. Total number of cases is over 40,000 cases. And of those, 23,000 have had a final decision issued. There are approximately 13,000-plus cases currently pending with NIOSH for dose reconstruction. I think that was something that came up earlier, how many -- how many are still at NIOSH. According to our calculations, that's just over 13,000.

We have about -- almost 2,000 that are pending action in our Department of Labor district offices. And those are cases in which they are developing the claims, they're obtaining employment information. They may be obtaining medical information or information on survivors, so they're in development, in process.

There are just over 2,000 that are currently pending a final decision with our final adjudication branch. We have a two-part adjudication process. The first step is the recommended decision which is made by our district office. The second step is the final decision which is made by our final adjudication branch. So that 2,000 that you see there, the cases have already received a recommended decision in our district office and are now at the final adjudication branch for a final decision.

And the amount of time that takes varies depending on what action is being taken. If an individual requests a hearing, that takes a little longer than if it's just a routine case that goes straight through and gets done within 75 days. So the time frames vary, but they do move those fairly quickly.

There you see some more statistics. This is -- these are at the claim level again. We jump back to the claim level. This is as of May 20th. Recommended decisions, there were 13,000 approved,

almost 20,000 denied. I have a slide later that shows the breakdown on the denials. For final decisions, over 12,000 approved, over 16,000 denied. And we've issued nearly 11,000 payments. This is compensation payments.

Now the reason why you'll see over 12,000 final decisions for approval and only 10,000 -- or almost 11,000 payments issued is some of those are -- were approved for beryllium sensitivity only and they do not receive a compensation payment. And then there are -- it takes a little bit of time from the final decision to when the actual payment is made, so it's -- the difference is a combination of those two things.

To date we've paid over $820 million in compensation to the claimants and over $33 million in medical benefits. And that has picked up, by the way, the medical benefits. We've already paid as much during this fiscal year as we paid in the entire last fiscal year, so that increases over time.

Here's a breakdown on the initial decisions. Again, our total number of

claims and total cases, and this also includes the number pending at NIOSH -- and that's at the case level. This basically is showing that we have taken initial -- completed our initial action, and we include a referral to NIOSH as a completion of our initial action -- for 95 percent of the cases that we've received. So we have a fairly small working inventory at this point.

Here are the final decisions. We've reached final decisions in 57 percent of the cases that we've received.

Now this gives you a little idea on the breakdown on the final decisions, the reasons for the denials. As you can see, over 12,000 final decisions to approve, over 16,000 final decisions to deny -- to deny. And of those 16,000, almost 10,000 were for non-covered conditions. That is 58.3 percent of the total denied claims were for non-covered conditions. So I think a lot of those were early claims where people were somewhat confused about the Part B program and the Part D program, and they went ahead

and made applications under both programs, even though they had conditions that were not covered under the Part D -- part B program. So that's a lot of what you're seeing there.

There are also some claims that have been denied because the employee was not covered. That's about 15 percent. Those are primarily people who worked outside of the time frames that are covered for the particular covered facility. They may have worked for Bethlehem Steel, for example. The covered period is during the early 1950's. They may have worked in later years and so they're not considered to be a covered employee for purposes of our program.

We have had some claims from individuals claiming survivor benefits who are not eligible survivors, so there's been a small percentage of those denied. And to date just a little over 1,200 have been denied because the cancer was not related to the work and/or the probability of causation was calculated as being less than 50

percent.

The next slide gives you some information on the status of the cases that we have referred to NIOSH to date. We've referred over 16,000. We've received back 2,940. Some of those were returned for reasons other than the dose reconstruction being completed. Of the ones that have been returned, 603 were accepted with recommended decisions, 1,747 were denied. And those have moved on to the final decision process and of those, 538 have been accepted and 931 have been denied. One thing we're seeing with the dose reconstruction cases is that we get a much higher rate of requests for hearings. That's why there is -- the acceptances go through very quickly. The denials go through a little less quickly because we have to take the time to -- to hold the hearing and consider all the arguments.

I thought you might be interested in some Bethlehem Steel statistics. We had a public meeting just a few weeks ago here in Buffalo concerning the Bethlehem Steel site

profile and dose reconstructions, so we had some information from that meeting that we have updated that I thought you would be interested in seeing.

We had a total of just over 1,000 cases filed from individuals or workers or survivors from Bethlehem Steel facility, and we've issued recommended decisions in most of those. There were 196 with approvals, 724 with denials. And final decisions, you can see the numbers there yourself. We've issued 186 payments on behalf of Bethlehem Steel workers, and we've paid out over $27 million in compensation.

Now not every case that we got in from Bethlehem Steel people went to NIOSH. A large proportion of them were for non-covered conditions, and we don't send those to NIOSH. So here you see we have sent 528 cases to NIOSH. Of those we've received 477 back, and you can see what the recommended decision and final decision breakdown is. And so -- I didn't do the percentage on this, but it looks to be about two-fifths accepted, three-fifths denied at the final

decision level on the Bethlehem Steel cases.

Now I want to give you a little caveat on these numbers. I had these slides prepared for me and I was looking them over and I realized that these POC ranges were very, very high for some of these cancers because -- due to the type of exposure there was at Bethlehem Steel, only certain cancers are going to end up being compensable at that facility. And what these POC ranges actually represent are combined values for some of these cancers, such as the bladder, the pancreas and the colon. These are combined values, the person had more than one primary cancer and that's why they're falling into the compensable range. So they did not -- the individuals whose POC range is represented here did not only have colon cancer or only pancreatic cancer or only bladder cancer, they had more than one primary cancer. But you can see, you know, there's quite a range on these.

You see prostate there. You know, normally if they -- somebody just had prostate cancer, they probably are not going

to be compensable. I have some later slides that give you a little bit more of an idea of what the POC range is for an individual primary cancer.

There've been a total of 628 cases denied from the Bethlehem Steel facility, and 225 of those were cases in which the probability of causation was less than 50 percent. And as you can see, condition not covered was a high number of the denials, as was employee not covered. And those were primarily, as I said before, people who were outside of the covered time frame for Bethlehem Steel.

We have a very active final adjudication branch and, you know, we're really just getting into the probability of causation cases. We've had a number of remands from Bethlehem Steel cases, a total of 42 to date. And one of those was a recommended decision to accept that was remanded and was eventually approved. And then the others, the other 41, were recommended decisions to deny. And of those, three of them were approved

ultimately, 20 of them did get a final denial, and there are a number of them that are still pending, and some were closed or withdrawn. And the ones that were closed or withdrawn, some of those may be the survivors are now -- or the employee is deceased or the survivor is deceased so we closed the case on those.

Here are the denied Bethlehem Steel cancer claims with the accompanying POC ranges, and I would say that these are probably more representative of a single cancer probability of causation ranges. And you have a copy of this in your folder of this -- you have a handout that contains these numbers if you can't see.

And then we looked at other New York State cases. We have over 1,000 other New York cases. These are people who worked at New York facilities. Now we haven't gotten too many dose reconstructions back on those yet, so that's why the numbers of approvals are so low on this. We do -- the number of denials is fairly high, but again, these are probably the non-covered conditions and

people who didn't work during the covered time frames. We sent 577 of these cases to NIOSH and have gotten 42 back.

We're doing a fair amount of outreach. I wanted to give you an idea of some things that have been developed and that we're working on since the last Advisory Board meeting.

We're going to be doing a traveling resource center for the Ames Laboratory in Iowa, and that will be the week of June 21st and we're working with DOE to advertise and coordinate. And this will provide face-to-face opportunity for claimants to come in and get assistance filling out claim forms, and they will also be prepared to address issues with claims that are currently pending with the Department of Labor.

And the reason we decided to go to Ames is that it was a large worker population at that site. It was in operation for a long time -- is in operation -- and we haven't gotten that many claims from Ames, so we were rather surprised with the small number of claims. So we -- in conjunction with the

Department of Energy -- decided that that would be a good place to go to.

Another project that our Cleveland district office is working on is working with an organization called Children of the Manhattan Project. And they will be attending a convention in Elmira, New York -- not too far away from here, a little distance -- during the week of June 24th. And we'll have an exhibit there and we'll do a presentation there to try to reach out to some of the people who are part of that organization and who are there attending that convention.

We also will be participating, along with NIOSH, in a panel discussion in Burlington, Iowa. This is I believe June 14th, and it will be similar to the meeting that we held a couple of weeks ago here in Buffalo, explaining the dose reconstruction process, the site profile and so on. And we'll have a -- it's a public meeting, so people will have the opportunity to ask questions.

Another recent outreach effort that

we've made is we attended a meeting with the Cancer Treatment Center of America, who have facilities throughout the country. This is more of a provider outreach opportunity, make sure that they know about the program, make sure that they have protocols in place to determine if someone who comes to them for treatment may be eligible for benefits under this program. And we've identified a lot of contacts through them for additional outreach.

And then another meeting that we're planning on attending June 27th through July 2nd is the meeting of the North American Pipe Trades, its conference that they're having. And we will have a booth at their conference and claim packages, and we'll provide assistance to people with questions.

So that's it in a nutshell.

**DR. ZIEMER:** Thank you. We'll open the floor now for questions or discussion. While others are thinking of questions, let me pose one. Have you compared the -- well, I'm going to call this success rate of claims for the NIOSH portion of the program

with the success rate of claims overall? Are they similar, very different, or maybe you haven't.

**MS. MOSIER:** It's -- really varies a lot according to the type of condition. For example, the chronic beryllium success rate is much higher. I don't have that statistic. We have looked at that periodically, but I don't have that statistic with me. I think currently it's running about 25, 30 percent on the cases that are returned from NIOSH. In other words, 25, 30 percent are found to be compensable. But that's not necessarily representative of what the rate is going to be eventually, so --

**DR. ZIEMER:** Right. Right.

**MR. GRIFFON:** Yeah, I'll just --

**DR. ZIEMER:** Mark Griffon.

**MR. GRIFFON:** I'll follow up on my same question that I asked of NIOSH. It seems like you have some pretty good statistics here, especially for Bethlehem. I wondered if you had similar statistics for all the NIOSH cases that have gone through for

approval or denial -- not only the range of POCs, but I'd like to see the number of cases in that range.

**MS. MOSIER:** Yeah, I mean we have -- we have the ability to produce that information. I don't have it with me, but we can -- that's something that we've -- we should be able to work with NIOSH on and come up with some...

**DR. ZIEMER:** That's by site and by type of cancer, apparently.

**MR. GRIFFON:** Yeah. Yeah.

**DR. ZIEMER:** Other...

**DR. MELIUS:** I apologize, I may have missed it, but on the other New York State cases referred to NIOSH --

**MS. MOSIER:** Uh-huh.

**DR. MELIUS:** -- what are the sites involved with those?

**MS. MOSIER:** I didn't get that information.

**DR. MELIUS:** Okay.

**MS. MOSIER:** But just guessing, you know -- looking at the approvals, I'm not sure what sites those are and I need to make

a phone call and find that out, but you know, it's all the -- all the sites in New York State, like Linde and Simonds Saw and Steel, and there's a whole -- whole gamut of them. We have -- there's a few sites in New York State that we don't have claims from, but we've got at least a few -- and several hundred, in some cases -- from all the New York State sites.

**DR. ZIEMER:** How about Brookhaven, do they have many cases?

**MS. MOSIER:** We've gotten some from them, but not a large number.

**DR. MELIUS:** They're small, I thought --

**MS. MOSIER:** Yeah, that actually --

**DR. MELIUS:** That may come up during Jim Neton's presentation later in the -- 'cause I -- I'm just trying to get a handle like, you know, Linde and Simonds Saw I would think would be the bigger ones, but...

**MS. MOSIER:** Yeah, and that information's available on our web site, too. If you go to the state statistics and you click on the state, first it lists

statistics in terms of residents of a state, but then below that it will show for each facility within that state how many claims we've received, how many have been approved and denied and so on, so that is broken out on our web site. And we update that every week. It's usually a couple of weeks behind, but it's fairly current.

**DR. MELIUS:** One other issue that came up at the meeting up here last month was some problems people were having -- and I think it's not just for the Department of Labor, but it came up in terms of some of the -- after their claim's been usually denied, there's a issue of whether they're going to appeal the claim and so forth, and I think it's a real difficulty people have and Jim and Larry referred to it earlier as to -- you know, they somehow feel that there's not complete information there or something's missing.

**MS. MOSIER:** Uh-huh.

**DR. MELIUS:** But they sort of don't know what steps -- they don't know what's missing or how -- how do you move something

forward, and it's a very awkward spot for people to be in and now, for example, with Bethlehem -- we're going to hear later from Jim Neton now -- they're now making some changes to the site profile which may or may not, you know, affect some of the claims and so forth. And is there a way of assuring that that information gets communicated to people? I mean it seems to me that they're reaching out -- I mean both DOL and NIOSH are making efforts to, you know, help -- help the claimants and so forth, but are there ways of assuring that -- that -- particularly for the NIOSH process, which is in progress and things are -- are changing and can be changing (Inaudible) not all the site profiles are complete and so forth, of assuring that that information gets to people and -- in a way 'cause I think it's very frustrating for the claimants and they're not quite sure what they should be asking for, but at the same time NIOSH has already acknowledged there's an issue and -- that they're trying to address and, you know, does DOL know that, and is DOL -- is

there a way of communicating that to the claimants in terms of their -- you know, what's -- you know, at the time of appeal or time of decision or -- or whatever. It seems to me there's some overlap that would be -- be helpful to make sure people know. I know some in Congress have talked about having an ombudsperson or ombuds office that would -- would provide sort of, you know, neutral assistance and I think that -- that might be helpful, but I think both agencies are also really trying to -- to do outreach and to be responsive, but --

**MS. MOSIER:** We really have made an effort to be responsive. I think -- there are a number of ways that we can do that. One is to make our decisions as transparent as possible and as plainly stated as possible so that the individuals who receive them understand what it is we're saying.

And then through the recommended decision and final decision process, they have the opportunity to come in and raise objections. I mean if they want a face-to-face meeting, they can have that face-to-

face meeting.

We've also been going out and doing these public meetings -- we've done a couple of them -- which I think has gone a long way, at least in this area, to help the individuals in that area understand more about the process.

Another thing that we've done is we've provided training for our resource centers on the dose reconstruction process so that the people who are working there have a clear understanding of it and they can meet with claimants and explain the process. If they get a letter from NIOSH and they don't understand what the letter's about, they can take their letter in there and they'll sit with them and explain what it means.

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

**MS. MOSIER:** Those are some of the things that we've --

**DR. MELIUS:** But then does the people in your resource center contact NIOSH to get an update on where things stand with that part of the program? I mean that may not be with the individual claim as much as with

that -- you know, with what's happening with that site, for example, something that...

**MS. MOSIER:** They're -- they're pretty in tune with that, I think. I mean we -- we put that information out to them and NIOSH keeps us advised, too. I mean we knew obviously about the change in Bethlehem Steel with the ingestion model and, you know, we -- it's hard to find the right balance at times because we don't want to get people unnecessarily excited about something that may not have an effect on the outcome eventually.

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

**MS. MOSIER:** So you know, we'll look at it and -- I guess you all are going to be talking about it a little bit later specifically, the Bethlehem Steel.

**MR. ELLIOTT:** I was just going to say that I think there's opportunity, though, for us -- I think your questions are very well-placed, Dr. Melius, and I think there's opportunity for us to be better coordinated, especially as we -- as we see these changes come about in site profiles. And as

Roberta's mentioned, you know, we notified their Cleveland district office that we were going to add ingestion to the Bethlehem Steel site profile and that we were going to re-evaluate all the denied claims that had been processed under the previous site profile without ingestion. And then we -- the plan would be that if we identified a particular case that was -- that ingestion had an influence on, we'd go back to the DOL district office, Cleveland, and talk to them about how to communicate this to the claimant and as we proceeded with, you know, revising the dose reconstruction. So I think, you know, it's timely that we look at new ways and better ways to communicate what's going on with these changes as they occur.

**DR. ZIEMER:** Thank you. Any additional comments or questions?

(No responses)

**DR. ZIEMER:** Okay, thank you, Roberta. Appreciate your input. Oh, hang on, Richard Espinosa has a comment.

**MR. ESPINOSA:** I'm just kind of

wondering if -- was there minutes taken on the meeting --

**DR. ZIEMER:** Use the mike, please. Use the mike, Rich.

**MR. ESPINOSA:** Was there minutes taken on the May 4th meeting? And if there is, can the Board get a copy of them?

**MS. MOSIER:** I'm not sure if there were -- I wasn't at --

**MR. ELLIOTT:** There were no minutes. There were no minutes taken. We did -- from NIOSH's perspective, we took notes ourselves. We made ourselves available after the second meeting at the -- in the evening meeting, the town hall meeting, we made ourselves available to individuals and -- because we can't talk about a claim in a public setting. People can talk about their claim, but we can't engage in that conversation in a public setting. We made ourselves available afterward on an individual basis. We took notes from that and we've made follow-up contact, and that's what we would intend to do at each one of these kinds of meetings. But there are no

minutes.

**DR. ZIEMER:** Again, thank you, Roberta, for your input to -- to the Board.

**REPORT ON ACCESS TO INFORMATION FOR PERFORMANCE OF DOSE RECONSTRUCTIONS**

Next we have a report on access to information. This is going to be presented by Grady Calhoun of the NIOSH staff, and you should have a packet I guess was just distributed.

**MR. CALHOUN:** All right. Can you hear me? I can't hear me.

All right. I'm here to give you an update or at least a synopsis of a report that we were requested to provide. This report is in response to National Defense Authorization Act for FY 2004, and the request was for NIOSH to report on the ability for us to obtain -- in a timely, accurate and complete manner -- information necessary to complete dose reconstructions. Part of that was to identify any matters that prevent us from the timely completion, list the number of claims affected by these matters, and also list the number of claims

that have not been able to be completed within 150 days of the time of receipt from Department of Labor.

One thing that we had to do here, since this is a fairly dynamic set of information, is we had to take a snapshot in order to come up with this report. We took a snapshot from what we had available as of January 15th, 2004.

First I'll go over what information is required for us to do a dose reconstruction. We need information from the Department of Labor, we need information from the Department of Energy and AWEs, and we need information from claimants.

What we get from the Department of Labor is personal information on the covered employee, date of birth, contact information so that we can make contact with them both in writing and by telephone. We need to know which facilities that they worked at, type of cancer that they had including the ICD-9 code -- and that's how the types of cancers are identified. Date of cancer diagnosis, ethnicity of the employee if the

primary cancer is a type of skin cancer. We need smoking history if the primary cancer is lung cancer or if the primary cancer is not identified or is of unknown origin, or if it's just a secondary cancer we need smoking history 'cause a lot of times we'll refer -- we end up calculating dose to the lung in that case. If the claimant is not the employee, if it's a survivor or representative, we need information on them, as well, for the same purposes, so that we can make -- contact information primarily so that we can make contact with them, both by telephone and in writing.

From the Department of Energy, as far as case-specific information, we request individual monitoring data for the people who worked at the sites, any diagnostic X-rays that they may have and any records of incident investigations that may have taken place throughout the history.

We also make batch data requests, and this is typically done at AWE facilities, but if we can't get individual monitoring data on, you know, John Doe, there may be a

batch of data out there covering many or most individuals that worked at a facility, and we'll make a request for that. Or sometimes we'll even go out and get that. AWE, I mentioned that.

Okay, information requested from DOE relative to site profile data. As we've touched on here, you know, we're doing the site profiles which play an important role in completing our dose reconstructions. And some of the things that we request from the Department of Energy are a detailed description of the radiation control program. We would like to know throughout the history of the sites what type of radiation dosimeters were used, how often were they read -- because that helps us determine what the missed dose would be -- and what kind of bioassay did they use. Did they use urinalysis, fecal analysis, were there whole body counts done, and what type of techniques were used. What type of bioassay and what were the limitations of those.

(Whereupon, Ms. Munn arrived and

assumed her place on the Board.)

**MR. CALHOUN:** We also ask for facility operations and radiological conditions. Through some contracts that we have, especially with some of the AWE facilities, we know what the types and amounts of radioactive material were that were processed through there, but we also will make that request from the Department of Energy, as well. Look for area radiological monitoring results, which play an important role, especially if individual monitoring results are not available for the employees. We look for environmental radiation levels in and around the facility. Many times these are in the form of environmental radiation reports that the sites publish.

We also request information from the claimants. One of the first contacts that we make is through the Computer Assisted Telephone Interview, the CATI, and we send the claimants the questions ahead of time, and then we contact them and try to get information on -- as much information as we can relative to where they worked and what

kind of protective measures were in place, what kind of things they worked with, if there were any incidents that they may have been involved in.

When we complete that we send it back to them as a draft, and we allow them to make comments on that. And if they have comments on that CATI, we'll fix that, add those changes, typically, and send it back to them. And sometimes that's an iterative process. I know that there's cases that we've had that have gone back two or three times until the claimant is satisfied with how it is written.

We also send them a completed draft dose reconstruction, and as was mentioned in here earlier, we do a closeout interview where we contact the claimant. We discuss the approaches that were taken for the dose reconstruction. And if they have comments on that, we may end up changing that dose reconstruction. And again, that can also be an iterative process that could possibly go back and forth a couple of times.

Signed OCAS-1 form. We touched on that

earlier today, as well. This is something that we really need. This is an important piece of information from the claimants. And as we talked about, what that -- what that indicates is that the claimants is done giving us information relative to their dose reconstruction. It's not an indication that they agree or disagree with the dose reconstruction. We get into some difficulties here, especially when there's multiple claimants, because we'd like to get an OCAS-1 back from all of the claimants, if they're survivors -- if there's multiple claimants on a single case. And we send them out a reminder at 60 days and at 74 days that if we don't receive that back, we may -- we can administratively close the case.

One of the next things that -- topics is what -- what's out there that potentially causes delays in us getting the dose reconstructions completed in a timely manner. And what we'll talk about is, again, from each of those entities, the information from Department of Labor,

information from DOE and information from the claimants that can cause delays.

Matters concerning information from DOL. Sometimes we get information that's not -- not complete, and examples of that would be incomplete employment period, incomplete cancer diagnosis information, ICD-9 codes may be incorrect. Typically we identify this through the dose reconstruction process, but we do have some -- data evaluation is done up front to see if there's any glaring errors that we can -- we can see to send that back and ask for clarification. When we do identify problems, or even potential problems, we'll ask the Department of Labor to send supplemental records, and they are more than glad to do that for us and it seems to be a very smooth process.

Another one that happens that's seemingly out of everybody's control is additional cancer diagnosis during case processing. Sometimes individuals will be diagnosed with additional cancers between the time that the case was submitted and the

draft dose reconstruction was completed.

Matters concerning information for DOE's data sources. Data does not exist in a readily-retrievable format. What we found, especially in the beginning of the program, is that some facilities had not established -- some DOE facilities had not established a program conducive to retrieving data on John Doe, for example. Some of the sites actually were filing data by year, so everybody's information as in each year, so to find information on John Doe, you had to know how many years he worked and go through, in some case, hundreds of boxes to find that information. So that -- that presented some problems early on.

Individual exposure records not located. In the case where we can't identify or find an individual's exposure records, we can resort to coworker data, and in those cases, too, we may have to rely quite heavily on site profile information.

Some dosimetry data was being supplied in summary form. For example, they would

give us annual doses. And what we ideally need is information on a per TLD or film badge read or urinalysis results basis. The individual numbers makes it much more easy for us to do a dose reconstruction. So in those cases we've gone back to the facilities and requested more detailed information.

Limitations concerning AWEs. Sometimes the AWEs are no longer in existence, they're not associated with the Department of Energy in many or most cases, and there's little incentive for them to respond to us in a timely manner.

Administrative matters affecting information from DOE. Again, I'll say initially, in the beginning of the program, we had some issues where the resources may or may not have been available. For example, when I listed the data does not exist in a readily-retrievable format, there was a significant undertaking by the Department of Energy at INEEL to get computer equipment in, extra staff and scanners to try to get that information out

of those boxes. They didn't stop at the cases that we requested. They continued to do that, so now it's much easier to get the information that we request. So DOE has been working to try to remedy those problems and have been successful in many of those areas.

Information from the claimants. Claimants may inadvertently provide inaccurate information. A lot of the claimants that we have are quite elderly and they may have a hard time remembering. They may not have been aware of the hazards that they were exposed to. Survivors -- it was a secret, lot of the things that people did was a secret, so the survivors know very, very little about what the individuals did.

Claimants may provide additional information after dose reconstruction is drafted. They may come back and say, you know, I forgot to write that I actually worked in another facility. And in that case, we'll have to go back and look for -- make a request to another DOE facility, and that has happened, so that could cause a bit

of a delay.

And we talked about that they may not return the OCAS-1 form within 60 days.

Matters concerning development of dose reconstruction program by NIOSH. We didn't have the infrastructure in place right away when we started receiving claims. We had probably thousands of claims in place before we had the infrastructure in place to deal with it, and we were doing them on a very small scale individually. In September of 2002 we did award a large support contract, which we needed drastically at that time.

We're also in the process of developing the site profiles, which we talked about today, and those are very, very important in getting the claims going and getting them out the door.

This is a little busy. I'm sorry about that, but what I wanted to try to show you -- I'll try to point this out a little bit to you 'cause not only is it hard to read here, it's hard to read in your handouts. But what this is is this is the -- this is the timeline of what it takes to

get a dose reconstruction done from start to finish. And that's receipt from DOL and sent the final back to DOL. This doesn't count the time that DOL takes going through final adjudication.

And I'm not going to go over all of these, but what I'll talk about -- we get the case -- as soon as we get the case, within a day or so, we'll request information from the Department of Energy. That's a fairly automated process. And we'll ask for the dosimetry information and what-not that I talked about a little earlier. We allow DOE 60 days to provide that information to us. Once we get that information, we review it for readability and also to make sure that it is of sufficient quality to do a dose reconstruction. We typically will -- we allow ourself seven days to get that done.

During that seven-day period, we send out interview communication letter to the claimant telling them hey, we're going to send you a -- conduct a computerized -- a Computer Assisted Telephone Interview, and

we send them the script to do that.

We allow ourselves -- the claimant is provided 14 days to review those questions that we give them. During that 14 days we'll call them to schedule an interview -- say hey, did you receive this information, when is a time that's convenient for us to talk to you, and we'll conduct that interview.

We allow a seven-day window to conduct the interview and during that time we'll send a -- after that's completed we'll send the draft interview report to the claimant, and as I mentioned earlier, they'll comment -- they have an opportunity to comment on that and we will send that back and -- with modifications.

We also will send a dose reconstruction introduction letter that says we have -- the following six, eight, ten people may be assigned to your dose reconstruction to complete it. Do you think that any of these people have a conflict of interest. They're allowed 14 days to respond to that, saying yeah, I don't want this person to do my dose

reconstruction.

So after that's all done, and we allow them 14 days to do that, we begin the dose reconstruction and we allot 60 days to complete that. When that's completed, we send that to the claimant.

The claimant has 60 days to comment, look at it, send the OCAS-1 back. During that time we'll call them and -- for a closeout interview and try to explain the processes that we've used, the approach that we used, and explain to them why they need to send back the OCAS-1 form.

When they send that OCAS-1 form back, we give ourselves two days to generate a final report and send that on to the Department of Labor, and at the same time we send that to Department -- Department of Labor and to the claimant, we send the final dose reconstruction report.

So if everybody takes the allotted time, it takes 228 days to get a dose reconstruction done from start to finish. Does it get done sooner than that? Sometimes it does. Sometimes it takes

longer, too.

Data quality review, I covered that. That's when we get the data in from the Department of Energy, we review that to ensure that it's what we asked for and that it's sufficient to complete the dose reconstruction.

One of the things we were asked to do is give a listing of the sites that were providing adequate information, as we have requested. And by looking at nearly all of the cases, all of the submittals from these facilities, these sites -- Savannah River, Hanford, Y-12, X-10, Rocky, K-26 and PNNL -- have requested well. This represents, by the way, approximately 50 percent of all the claims.

Sites providing adequate response to data, basically the same thing. However, we haven't had a chance to look at all of the submittals, but just looking at a random sample of them, it appears to us that all of these facilities are providing data that's sufficient for us to complete a dose reconstruction. And I won't go over all of

those. They're in your handout.

Site with special consideration, Mallinckrodt. The data for Mallinckrodt was available through EML, Environmental Management -- Measurements Laboratory in a stash that we have gone out and done a data capture for.

Iowa Ordnance Plant was -- the data was available at University of Iowa, Department of Defense and ORAU. And Shippingport, the data -- data source was Atlanta National Archives. So in these cases we make requests and/or actually go out and do data capture and get as much information as we can.

One site, Trinity Nuclear Explosion Site, had one request for information and no DOE submittals have been received. I tried to get an update for this presentation, and we still have not received it and I have no reason as to why we haven't received it.

Sites not consistently providing adequate response to -- for requests, Los Alamos, Los Alamos Medical Center, Pantex, Brookhaven National Lab, Stanford Linear

Accelerator Facility and Oak Ridge Hospital. Some of the specific deficiencies are that we have had some difficulty with Los Alamos not providing individual bioassay data. I know that there's been a lot of discussion between that point -- between the point of this report and today with Los Alamos to try to get that, and I believe that we've at least got a path forward. But I don't think that it's still where we need it to be.

Medical Center, that's kind of an interesting situation because they're no longer associated with the Department of Energy. I have actually personally contacted them and have gotten some information on a claimant, but it took a long, long time, but they do have some information.

Pantex Plant, Pantex in general provides pretty good information, but they are also responsible for the Medina facility and their Clarksville facility, so they kind of get dinged for that. But it seems that the stuff directly from Pantex is pretty good.

Brookhaven has not submitted raw bioassay data or detailed external dosimetry data.

Stanford Linear Accelerator Facility has only provided summary data, such as annual summaries. The individual reads that we would like has not been provided.

Oak Ridge Hospital's pretty much the same as Los Alamos Medical Center, they're no longer associated with the Department of Energy, so it's a little bit more difficult to get information from them.

DOE support of development of site profiles. We are working for the development of 15 profiles for some of the bigger DOE sites. DOE has been supportive in assisting us to locate and find the characterization information, although it is sometimes difficult to get. Some of the delays that we have had have -- have to do with security issues. You know, in some cases the information is there. We have several people -- many people that are -- have the clearances to get it. It's just a matter of getting it and how do we use it in

a way that still maintains the security that is necessary.

Number of claims requiring dose reconstruction. As of January the 15th, the time of this report, a little over 15,000 cases we had received from the Department of Labor. As of May 26th we'd received approximately 16,400 cases for dose reconstruction.

One of the final things asked for in this report was how many -- how many dose reconstructions have been affected by this, and almost -- almost all of them have been affected in some way or another. And the question was, how many have been affected by -- by any of these matters that could affect them and how many cases have required more than 150 days for completion. Well, as I showed in that very busy slide, if people take all of the time -- or just the amount of time that's allotted to them, it's going to take more than 150 days, so a big portion of the cases are likely to require more than 150 days because of the time that we've built in for the claimants to review,

respond, and for us to get back to them.

Conclusion, you know, we're continuing to -- to complete more dose reconstructions. Our rate is increasing. It's been a painful process sometimes, but we are getting good cooperation from the Department of Labor and Department of Energy, and always working to try to increase that capacity so we get dose reconstructions completed. But ultimately it's not been as rapid as we would all have liked to have seen it. But like I said, we're -- we're pretty hopeful that things are -- we're seeing things going up and we're hoping to see that trend increase.

Any questions? That's the last slide, I believe. Yes.

**DR. ZIEMER:** Grady, one of the themes that emerged over the months from public comments was the idea that many of the claimants seem to think there was a great burden on them to provide information in this telephone interview, that somehow the burden of doing a dose reconstruction was very dependent on them providing detailed information on dose or locations and so on.

Are we doing a better job at making clear that dose reconstruction's not so dependent on them coming up with all the answers? And not only claimants, but survivors, who knew even less, as you indicated.

**MR. CALHOUN:** You know, I don't --

**DR. ZIEMER:** Is that still an issue with claimants that --

**MR. CALHOUN:** I don't know, I have -- I don't know if -- if we're getting a lot of complaints about that. I know that that was an issue because certainly you look at that -- just a part of that script, if you will, and you have all the radioisotopes listed down there and a lot of times we're getting no, but it looks like I'm going to get saved here by Dr. Toohey --

**DR. ZIEMER:** Yeah, maybe Dick Toohey can answer that, but there -- we seem to get that a lot from individuals who commented, concerns that we were depending on them somehow to come up with all the answers.

**DR. TOOHEY:** Well, in fact it was something I was planning on discussing in my presentation on the CATI process. And of

the complaints we do get in about the CATI process now, which aren't many, but most of them do fall into that category. I don't have the information you're requesting in this questionnaire. We -- if it comes in up front, we try to contact the claimant and as part of the interview scheduling process say no, that's okay. This is just -- let -- let us know whatever you've got, and if you don't have anything, you know, that's fine. It's not going to hurt your dose reconstruction. We're just trying to get from you any information you may have that we didn't get from DOE or other sources. And also in the case of survivors, that group specifically, requests for information on coworkers that we might be able to contact to help out.

What I've also noticed is that groups of claimants who have an advocate -- I'll use Mallinckrodt with Denise Brock and her United Nuclear Weapon Worker organization -- Denise has done an excellent job educating the claimants about what it's all about and what we try to capture in this. So the

number of those complaints has dropped off. It's still an issue, but it's not as great as it was say a year ago.

**DR. ZIEMER:** Thank you. Okay, Rich, and then we'll go right around the circle.

**MR. ESPINOSA:** Go ahead.

**DR. ZIEMER:** Okay. Gen?

**DR. ROESSLER:** Yeah, Grady, your busy slide was busy, but it's particularly informative, I think. And I want to just have you go back to that one, if you would --

**MR. CALHOUN:** I think I can do that.

**DR. ROESSLER:** -- dose reconstruction timeline.

**MR. CALHOUN:** All right.

**DR. ROESSLER:** I think this was helpful not only to us on the Board, but it should be very helpful to claimants and members of the public when we talk about this whole process. And the bottom line, and I think you implied this, really in most cases it does take 240 days or almost that long to do it. Two of these big chunks are 25 percent -- I mean two of them are half of that time,

but apparently there's nothing you can do to control it. Twenty-five percent of the time is with the claimant themselves, and I think you probably don't want to -- wouldn't -- you can't change that. Twenty-five percent of the time is with DOE. I guess that's built in, that's --

**MR. CALHOUN:** Yeah.

**DR. ROESSLER:** -- allowed for DOE. Another 25 percent is to do the dose reconstruction. I suppose that's the only part that really could be substantially shortened.

**MR. CALHOUN:** Yeah, and the way this works is when we -- we'll send out a batch of letters and it -- to inform people that we're going to start their dose reconstruction, and you know, some dose reconstructions can be done -- once all the information is there -- in a day, and some of them take much, much longer to do, depending on what kinds of information that --

**DR. ROESSLER:** But even if you shorten that to half the time or whatever, it still

doesn't --

**MR. CALHOUN:** It still gets us down to --

**DR. ROESSLER:** Yeah, it's still --

**MR. CALHOUN:** -- 200 days.

**DR. ROESSLER:** Realistically, the way it's set up, allowing time for the claimant and allowing time for DOE, there's not much that can be done to shorten the time. I think -- I mean I didn't realize this and I appreciate this slide -- and my eyes are pretty good so I can see it, but...

**MR. CALHOUN:** Yeah, and that is in the report. That was an attachment from the report. It's easier to read there, I think.

**DR. ZIEMER:** Yeah. In fact, if you can read what's in your booklet, you're much too young to be on this Board.

**DR. ROESSLER:** Thank you, Paul.

**DR. ZIEMER:** Leon. Oh, no, okay, Ray -- Roy.

**DR. DEHART:** Thank you. A point of clarification. In one of the earlier slides you had indicated that one of the bits of information you're wanting is the records of

any diagnostic X-rays.

**MR. CALHOUN:** Correct.

**DR. DEHART:** Point of clarification would be isn't what you're really asking for those employee-req-- employer-required --

**MR. CALHOUN:** Yes, sir.

**DR. DEHART:** -- surveillance films.

**MR. CALHOUN:** Yes, sir.

**DR. DEHART:** Not diagnostic X-rays.

**MR. CALHOUN:** Yes. That's correct. Now we don't -- we actually will make that distinction, but a lot of times we'll get it -- we'll get it all, and that's okay. As long as we're getting something, that's good. But we also established a mechanism for them to provide -- them being DOE sites -- to provide to us a history of the required X-rays that were done throughout the time, and some of those that we're getting are very detailed. They give us the type of machine, the exposure -- all the exposure parameters, how often they may have had these examinations. So in those cases we don't even need the records from the DOE on that individual because we've got the

program laid out.

**DR. DEHART:** But you're not using diagnostic X-ray data that is clinical based and not work based.

**MR. CALHOUN:** Correct. That's a true statement. Even if they break a leg on the job or get injured and an X-ray's performed, that is not part of it.

**DR. ZIEMER:** Jim.

**DR. MELIUS:** Yeah, got three questions. First one is related to these timeline goals and so forth is -- and I think with the new way that you're reporting on your web site progress that I think you capture some of this, but -- but have you analyzed how long it's taking -- actually taking for each step? And I also think you have some delay steps that aren't up there. I mean these are sort of ideal, but what hap-- you know, you're waiting -- you don't have enough health physicists to do the dose reconstruction so there's a queue waiting --

**MR. CALHOUN:** That's true --

**DR. MELIUS:** -- to get --

**MR. CALHOUN:** -- that is, that is.

**DR. MELIUS:** Yeah. But is there an analysis of how long each of these steps are actually taking?

**MR. CALHOUN:** I won't say that there's an analysis per se, but these are all tracked.

**DR. MELIUS:** Okay.

**MR. CALHOUN:** And we can go in, for example, and find out that we submit -- we sent a draft dose reconstruction on April 1st and it's getting close to the time for us to send him a reminder letter. We also track when we perform the closeout interview, so we -- we know -- really that's a tool so nothing falls through the cracks, so that we continue to communicate with the -- with the claimant.

**DR. MELIUS:** Yeah, but it's also a resource management --

**MR. CALHOUN:** Yes.

**DR. MELIUS:** -- to all the -- second comment is regarding your -- you don't need to put the slide back up -- is -- is you titled matters concerning information from claimants --

**MR. CALHOUN:** Uh-huh.

**DR. MELIUS:** -- about the interview process.

**MR. CALHOUN:** Right.

**DR. MELIUS:** I think you're being a little disingenuous and sort of not -- I mean one of the possible problems certainly may be that you're trying -- not trying to elicit the correct information or the complete information, the nature of your interview is not adequate to address and pick up this information. I know you don't like to admit that, but I think it's becoming more and more of an issue I think as we start to see some of the reasons for the delay.

Now we'll discuss this I think later when Dick Toohey is going to present on the QA/QC aspects of this, but it's another -- your slide there implies that it's all the claimant's fault --

**MR. CALHOUN:** No.

**DR. MELIUS:** -- and I think that's -- you know, they may not be really being asked the right --

**MR. CALHOUN:** Uh-huh.

**DR. MELIUS:** -- to provide the right information or give them the -- that. And then I think there's another part of that that is very problematic. And again Dick really brought it up in terms of -- of people -- to some extent a lot of this information is really relying on what other claimants or other informants can provide, and that's a very difficult part of that process 'cause --

**MR. CALHOUN:** Yeah.

**DR. MELIUS:** -- you don't know who those people are ahead of time and --

**MR. CALHOUN:** Right.

**DR. MELIUS:** -- so forth. My final question is -- concerns the specific deficiencies and I'd like to hear what is being done to resolve the issue with Los Alamos.

**MR. CALHOUN:** I believe -- I don't know if Jim has any more information on that, but I know that we've been in contact with Los Alamos and are in the process of getting their bioassay database, but go ahead.

**DR. NETON:** (Off microphone) Right, the Los Alamos situation I think is on the right track and (Inaudible) forward. The issue there was with the bioassay database. (On microphone) They were in multiple versions. There were multiple databases one had to search, and the pedigree of the information in the database was -- was somewhat suspect. So we've worked very closely with them to the point where we've actually provided a contract support person to work with Los Alamos to re-engineer their database into one consolidated system. We've met several times with them and that's moving forward, and we hope to start getting those dose reconstructions -- the information for the internal dose reconstructions fairly shortly. It's been a really good experience on our part, once we all identified what the problem was and got some resources allocated to the right issues.

**DR. MELIUS:** What about the detailed external dosimetry data?

**DR. NETON:** That's at Los Alamos?

**DR. MELIUS:** That's what it says.

**DR. NETON:** Yeah, the detailed external dosimetry data is not as big a problem. For the most part we are getting detailed dosimetry data. There are some issues that we're working through with them. Most of the issues related to lower-level exposures and we've increased that threshold. In the early days we requested individual dosimetry data for any dosimeter that was -- any person that had less -- more than 100 millirem annual exposure, the idea being that with that low level of an exposure, we could substitute missed dose and -- and you know, assume that the 100 millirem occurred in one monitoring period, and then substitute missed dose for the rest of the year. It's been our experience that we -- you know, we can get by with a higher threshold if we move that up to 500 millirem now. That's alleviating some of the issues.

The problem with low-level exposures is oftentimes these weren't recorded. If it's less than a certain level, it just wasn't put in the database. So we're working around that. I don't think that this is a

big issue at Los Alamos at this point. Remember, this was taken back in -- the snapshot back in January and I think we've worked through that issue.

**DR. MELIUS:** And what verification is there for things that are going into the database if you're not working -- not accessing primary data?

**DR. NETON:** Right. We're working closely with the site, you know, the folks that are very familiar with the databases themselves. I mean we are assisting. We're providing the pair of hands that do the programming, but we're working with the folks like Guthrie Miller and those people at Los Alamos to verify the individual -- the individual urinalysis sample results. I mean that's what we're looking to get, and what the detection limits were, those sort of things, and -- you know, frankly, it's sort of a painstaking process, but we're -- we're working with them.

**DR. MELIUS:** Yeah. Just a comment, not that you are taking shortcuts and now that -- not that you don't need to be -- have some

efficiency in the process, but I think it's very important for the credibility of the program that there not be a mistake here. We don't want to have to go back and -- I mean and find out that you were using incomplete or incorrect data 'cause it -- you know, and have processed a bunch of claims. I think it's -- some cases much worse than an issue with, you know, a site profile or something like that.

**DR. NETON:** Absolutely. I don't want to leave the impression that it's all -- all internal bioassay results for Los Alamos. It really applied -- I think we have something on the order of 400 claims -- cases from Los Alamos. This may affect about 200, and it primarily affects the uranium bioassay program that we're focusing on, has to do with the degree of enrichment and that sort of thing. But yeah, we're aware of those issues and taking them very seriously.

**DR. MELIUS:** 'Cause as you describe it in the report, it seemed more serious and it may have improved since then somewhat.

**DR. NETON:** Yeah.

**DR. MELIUS:** Thank you.

**DR. ZIEMER:** For my own information, Grady, I'll ask -- and maybe Roy or Robert can answer, but what is the Oak Ridge Hospital? That is -- was it part of the Laboratory at one time or...

**MR. CALHOUN:** Good, I'm getting saved again.

**MR. PRESLEY:** Oak Ridge Hospital was part of --

**DR. ZIEMER:** Use the mike.

**MR. PRESLEY:** All right. Oak Ridge Hospital in its early years was part of the Federal government, and then it was turned over to the Methodist Church.

**DR. ZIEMER:** So that's what I call Methodist Hospital?

**MR. PRESLEY:** Yes.

**DR. ZIEMER:** Okay, thank you. I know what that is. In fact, my first daughter was born there. I wasn't sure if that was one time what this referred to. Thank you. Mark?

**MR. GRIFFON:** This -- really I had a

question on the coworker database and I think that's probably better saved for later. I don't know if it's under Jim Neton's presentation or what, but I think just to get it out here, I'd like a description of how that's being put together, how coworker is being defined and what kind of data you're collecting in that database, so I don't think you --

**MR. CALHOUN:** I think that would probably be better for Jim or Dr. Toohey.

**DR. NETON:** We can talk about that.

**MR. CALHOUN:** Yeah.

**DR. ZIEMER:** Okay. Richard?

**MR. ESPINOSA:** Yeah, well, same as Dr. Ziemer's question with Los Alamos Medical Center, are you talking about the hospital or...

**MR. CALHOUN:** It's actually listed as the Los Alamos Medical Center, and it is -- it is the hospital. I've actually -- you know, the one time that I was -- that I had to contact them and I was successful, I went through one of the resource center people and talked to them, and it was associated

with the Department of Energy at one time. And when I -- the time frame that I was looking at was in the early '50's and they are no longer associated with Department of Energy at all anymore. I don't know who owns them, but it's -- it's pri--

**MR. ESPINOSA:** (Inaudible) it's Lovelace* now?

**MR. CALHOUN:** I'm not that familiar with that out there.

**DR. ZIEMER:** Thank you. Further questions or comments?

(No responses)

**DR. ZIEMER:** Okay. Grady, we thank you for a very informative presentation.

We're now at the noon hour, at least for those on east coast time. We're glad to have Wanda join us. It's early morning there in Richland.

There's a restaurant guide. Is there just the one restaurant guide?

**MS. HOMER:** No, I have a number of them --

**DR. ZIEMER:** There's a number of restaurant guides that give you lots of

options here. Avail yourselves of those, if you wish. We'll recess till 1:30. (12:00 p.m.)

(Whereupon, a luncheon recess was taken.)

(1:30 p.m.)

**ANNUAL ETHICS TRAINING**

**DR. ZIEMER:** I'm going to begin this afternoon by introducing David Naimon. David is a member of the legal staff for Department of Health and Human Services, and David's going to introduce to us our speaker for the next topic, which is our annual ethics training.

**MR. NAIMON:** Thank you, Dr. Ziemer. As the Board members know, we have an annual requirement for ethics training, and on behalf of the HHS Office of General Counsel I wanted to welcome and thank John Condray, who is coming today to give you your -- your ethics training. John is not only one of HHS's top ethics experts, but really one of the top ethics experts in the Federal government.

He has been working in the field of government ethics for more than 16 years, first with two years at the Internal Revenue Service, then with ten years at the U.S. Office of Government Ethics, which is the office that coordinates all the ethics-related activities for the Federal government, and then three years at the National Institutes of Health. And then since last year he's been in the ethics division of the Office of General Counsel where his primary client is the Centers for Disease Control and Prevention, which of course includes NIOSH.

John got his bachelor's degree from the University of Maryland and his law degree from the Georgetown Law Center, so we're -- we feel very lucky that he agreed to travel here today in order to discuss these very important issues with all of you. Thank you.

**MR. CONDRAY:** Thank you, David. I must say I -- I've been introduced before, but I've never had my -- the person doing my introduction be introduced before, so I come

to you this afternoon as the third domino in the list.

I saw several eyes light up at the entertaining prospect of an ethics lawyer who is working for the Internal Revenue Service, and I -- and I can tell you that one of the great things about coming to the Department of Health and Human Services, after working for two years as an ethics lawyer for the IRS and then ten years an attorney at the Office of Government Ethics, I was glad to have a job that was not in fact in itself a punch line.

And the -- the -- and that's well and good, because the ethics considerations are issues that -- although we can be flip about them -- and believe me, if you work for ten years at the Office of Government Ethics, you hear every single joke about government ethics that are in the lexicon -- the important -- the thing is that these issues do matter because they can -- they can trap the unwary and they can open up what -- valuable government work to collateral attack on ethics grounds. And that's

unfortunately been something that's becoming more and more prevalent, and so that's one of the reasons that the Office of Government Ethics has mandated the annual ethics training requirement for many -- many categories of senior government employees, including special government employees who are serving on advisory committees.

My objectives this afternoon -- in a one-hour presentation I am going to make absolutely none of you a subject matter expert in the field of government ethics, and I realize this. What I'm really shooting for is that you obtain a general familiarity with the conflict of interest rules that are applicable to special government employees and also to create what a former colleague of mine used to refer to as the wart on the edge of the nose. You may not necessarily know the ins and outs of government ethics, but hopefully it'll give you an idea of where these issues come up. And you think, like a wart on the end of a nose, you kind of look and say I wonder if I should get somebody to look at that, and

that's what this lecture is this morning, to try to get you guys to -- to recognize when it is that you want to consult with somebody about these issues, and also knowing where to go when and if you do have a question.

After the introduction, the -- I'm going to spend the time outlining the key ethics rules. After you leave today, you hopefully all have this publication, which was done by my office, the ethics division of the Office of General Counsel. It's a part of your materials for the course today -- for the meeting today. And that has, in much greater detail, information on everything that I'm going to talk about this afternoon. So if there's a particular question or an area that you think might be particularly pertinent to your situation, I would recommend that you consult also with that particular handout before -- to sort of educate you on how to phrase a question that you might bring to the committee management. And hopefully we'll have a chance to look at -- to do some brief Q and A, depending on the time after my presentation winds up.

The ethics program in the government, particularly for advisory committee members, the first line of review that you see is financial disclosure. All committee members are required to file financial disclosure, and these forms are then reviewed and potential conflicts are identified. Once a conflict is identified, then the conflict is resolved through a number of methods. The primary methods are recusal or disqualification. That's merely stepping out an involvement in a matter where a committee member would have an interest. Or where appropriate, sometimes waivers are issued. And even -- and during the course of service on the committee there are conduct rules that apply and because it's a -- we can reach you even after you leave the committee, there are a few restrictions that apply even after you have -- a committee member has left government service.

We'll start with the financial disclosure. As I said, all committee members who are appointed as special government employees are required under the

Ethics in Government Act to file a financial disclosure report. This is an OGE-450. The information that's on the report is used to do an initial conflicts check and determine whether a waiver is necessary or appropriate. I want to add one point to that aspect of financial disclosure, which is that although the agency will review a financial disclosure report and -- and that will enable the agency to have an idea of when there might be a situation that would present a conflict of interest, merely filing a financial disclosure report does not place the onus for main-- for following the financial disclosure statutes on the agency. The onus is on the individual employee, as it is for all Executive Branch employees, to stay in compliance with the conflict of interest statutes and regulations.

I use -- a quick example of this. It can trip up even people in very senior positions. At the -- some of you may be familiar with the case of Marvin Runyon, who's the former Postmaster General of the

United States. He filed a financial disclosure report which indicated that he had large holdings in Coca-Cola stock and he agreed to divest himself of those interests. Unfortunately through a -- some sort of communication error with his broker, the Coca-Cola stock was never divested, a fact which turned up on a number of statements that he received throughout following years. Fast forward a couple of years and Marvin Runyon decides it's a great idea for the Postal Service to put Coke machines in Post Offices.

Well, someone -- some sharp-eyed person noticed that Marvin Runyon was still listed on his financial disclosure reports as having Coca-Cola stock, and that -- that fact came up and Marvin Runyon was not only forced to resign as Postmaster General, but was actually prosecuted by the Department of Justice. And he attempted to use the defense to the prosecution that the -- the agency knew or should have been aware of the fact that he had these holdings because of the financial disclosure reports. And the

Department of Justice was unmoved by this defense and ultimately he settled for the largest criminal penalty -- or criminal fine that was ever placed on a conflict of interest case.

And unfortunately, stigma of that sort of thing can last into your professional career. Mr. Runyon died within the past few months and I could not help but notice that as a part of his obituary a prominent mention was made of the fact that he had been the Postmaster General of the United States but had been forced to resign due to conflict of interest problems. And so I would counsel all committee members, the same way I counsel all Federal employees, be aware of what you have. Know what you have. The defense of I never read my statements anyway doesn't really wash because the -- the -- after-the-fact as a justification, it's not very powerful and won't serve as a defense.

The statute that tripped up Marvin Runyon, the conflict of interest statute -- this is the basic Federal conflict of

interest statute, 18 U.S.C. Section 208(a). All Executive Branch employees are prohibited from participating in any matter that would -- particular matter that would affect their financial interests, including those that are attributed to the employee.

The matters that -- the types of interests that are attributed to the employee, these include the interests of a spouse, of a dependent child, of an organization that the employee is serving as an officer or director or trustee or employee, and also any organization that the government employee is currently negotiating with for future employment.

You'll hear me use the term "particular matter" and "particular matter involving specific parties", and also "broad policy matter". These are terms of art in the ethics area. And a way of thinking about them is to -- is who is being affected by the consideration -- by the -- by what is being -- the issue that's being treated by the committee. A recommendation, for example, on a methodology for making a

dosage determination would be a particular matter affecting a discrete and identifiable class, in this case the nuclear industry and/or its employees.

You'll also hear the term "specific party matter". A specific party matter is typically a proceeding that adjudicates the rights and responsibilities of individual parties, be they individuals or organizations. Typically these are grants or contracts or investigations or proceedings, the types of things that have specific individuals or companies attached to them.

This committee is very unusual. Most advisory committees do not hear specific party matters. However, a Special Exposure Cohort for a specific location would be a specific party matter, so there's some matter -- so there will be some things which will be of particular interest for this committee as opposed to for most advisory committees as I go through my lecture this afternoon.

When you have a financial interest or a

conflict -- potentially a conflicting financial interest, the way -- the primary method for dealing with these is recusal or disqualification. You'll hear the two terms used interchangeably. The ethics laws -- because what's prohibited by 208 is an employee or SGE participating in a matter in which the employee has a financial interest, the remedy is not to participate. It's pretty straightforward when you think of it in that fashion. They -- basically the employee steps out of all con-- all considerations and proceedings that concerns the matter in which that they have a financial interest.

Now the statute itself does not have a de minimis provision, so because of the potentially broad reach of the conflict of interest statute, Congress has designed both general and individual waivers, and these general and individual waivers have been further explained in regulations that are issued by the Office of Government Ethics.

The -- you'll -- there are broad waivers, regulatory waivers, and these are

determinations by the Office of Government Ethics that -- when you're talking about an area -- one of these areas, any sort of conflict that would arise out of these particular ties would be so remote or so insubstantial that it would not present a conflict of interest to a reasonable person. The -- for -- term of art that's used by OGE sometime is not so substantial as to affect the integrity of an employee's services.

For example, there's a de minimis waiver for certain stock holdings in a publicly traded company that -- that de minimis amount is $15,000 for specific party matters or $25,000 for particular matters of general applicability. And I note that that would be for a -- a cautionary note is if you have an interest which is close to that amount, it -- that can be something that you might want to consider talking to the committee management about because you don't want to be in a situation where you're -- you think you're covered by a waiver, there's a spike in the stock price, suddenly your stock price is worth over the

regulatory amount and you don't have a fall-back position and therefore you are -- you are suddenly required to step out of a matter that you'd previously been involved with.

There's also the -- that apply specifically for special government employees who are serving on advisory committees. There's a waiver saying that for particular matters of general applicability that arise out of the committee member's employment -- any interest that -- that -- financial interest that arises solely out of -- as a result of your employment is not considered to be a conflict of interest.

Now if you have a stock holding -- this only applies to the straight employment relationship. If you also have stock holdings in a company that employs you, then this waiver would not apply to that. And I also note, very importantly, is that this waiver is for particular matters of general applicability only. It's not for specific party matters. Therefore if your employee -

- if your employer is a party to or going to be one of the affected entities in a specific party matter, then in that situation you would still be obligated to recuse yourself, notwithstanding the fact that this waiver exists.

There are also individual waivers. In a specific situation the agency has the authority -- and this is authority that's been granted under the conflict of interest statute to the agency directly -- to grant individual waivers where the agenc-- the agency determines in writing that a financial interest is not so substantial as to affect the integrity of the -- of an employee's official duties. That's a very difficult standard to reach. They -- and -- and so waivers are actually very rare. But for special government employees the statute sets up a different status -- different standard, be-- that -- and that's because of the special role of advisory committees.

Advisory committees, because of the requirement for -- under the Federal Advisory Committee Act for a balanced

membership and all of those other -- those other provisions that acquire -- apply under the FACA, and also because of the fact that the advisory committee's determinations are advisory in nature and must be approved by the governing -- government authority, the -- a special waiver standard was set up for advisory committee members. They -- an advi-- an advisory committee member may -- may receive a waiver if it's determined that the need for an employee's services outweighs the potential for a conflict of interest, and waivers therefore are fairly commonly issued for particular matters of general applicability.

I would note that even for advisory committee members, they are -- I want to say never, but the lawyer in me shuns absolutes, but I'm not aware of a single situation where a -- a waiver was issued for a specific party matter. So in that situation, we would prefer to -- to deal with conflicts that arise through the method of recusal or disqualification.

Another method for dealing with

conflicts of interest, which I -- which I'd just like to mention, is divestiture. It's very rare that divesting an asset or a financial interest is done in the situation of an advisory committee because of the -- the -- the nature of the employment. You're only here for a few days out of a year. It seems rather draconian to require a member to eliminate a financial holding under the conflict of interest statute. That is, however, done fairly frequently for regular government employees, and there's even a particular provision within the tax code under certain circumstances where the -- the divesting of a conflicting asset will not be recognized for tax purposes. The -- I invariably get -- because one of the attributed interests under the conflict of interest statute is the financial interest of your spouse, it's not uncommon for me to -- people to ask if divorcing one's spouse is a means of getting rid of a financial conflict of interest. The answer is technically, yes. But we don't encourage that.

There are a few other criminal statutes in addition to -- in addition to the -- the -- the 208, the financial conflict of interest statute. Now I just want to briefly touch on these statutes, as well. The basic one is 201 -- 18 U.S.C. 201, the bribery statute. As with all other Federal government employees, special government employees may not accept anything of value for being influenced in the performance of an official act. That means anything. There's no de minimis for this. Even if you're cheap, it's still a bribe, and therefore it's considered -- it'll violate the statute. And I'll notice that -- that -- I mention that -- I also touch upon that 'cause I -- later on I'll talk about gift exceptions, and there's a gift exception permitting the -- the extravagant de minimis value of $20 value in gift from -- from a person. However, if you can be bought for $15, even though it's a de minimis exception to the gift rule, it still violates a criminal statute and -- and you would be prosecuted for that, in addition to just --

if $15 buys a Federal government employee, we're all in very deep trouble.

There are also representational restrictions. Sections 203 and 205 -- and I have to say that -- that if -- if you find some of these hard to conceptualize, I will rather blushingly admit that I was a conflict of interest lawyer for about two years before I could really articulate the difference between 203 and 205. Both of these statutes deal with making representational services to the -- back to the government during the tenure in wh-- that you are a special government employee. And I'll notice that these rules are much milder for special government employees than they are for regular employees.

Under -- 203 is compensation-driven. Under Section 203, a special government employee may not receive compensation for representational services that it -- before an -- any -- any agency or court in connection with a specific party matter in which the SGE personally and substantially worked on. They -- there are a lot of terms

of art in there. Specific party matter is one that we've already gone over. The -- the important thing to consider is that if you are -- have worked on, for example, a specific exposure cohort, then you cannot represent another party or receive compensation for representational services for -- in connection with filing -- with filing a claim against or challenging in -- in a -- an action that particular determination before a Federal agency or court.

Now it only applies to -- to -- to testimony before an agency or court, and I will also note that -- that on the expansive end, if you are involved in -- and this is particularly applicable to lawyers, and hopefully there aren't terri-- a tremendous number of lawyers in the room, but also for any professional partnership. If you are receiving partnership income for -- and -- and your partnership is going to engage in representational activities, in that situation please contact us and we need to make sure if this -- if 203 is going to

become an issue because -- and the reason that it would is because there -- it -- it bars -- prohib-- it prohibits compensation for representational services. You don't have to be the person who's making the representation. What's required for a violation of 203 is that compen-- that you be receiving compensation in connection with representational services rendered by someone.

205 is both broader and more particular, in that 205 does not require compensation. The -- a special government employee may not act as agent or attorney for any other party before a Federal agency or court in connection with a specific party matter that the SGE worked personally and substantially on. It's broader because there's no compensation requirement. It's narrower because it only affects the actions of the special government employee.

On the off chance that a special government employee works more than 60 days in a calendar year, the 203 and 205 restrictions expand at that point to include

any covered matters that are pending before the -- the Department of Health and Human Services through your agency, and that would be acting as an agent or attorney, with or without compensation, or receiving compensation for representational services for any matter that would be before the Department of Health and Human Services. However, for -- for -- that has a specific day -- days re-- number of days requirement, which is not typically triggered in an advisory committee setting.

There are statutes that apply after you leave the government, as well. The primary post-employment statute, 18 U.S.C. 207 -- 207(a)(1) is the -- the -- the most important restriction. That is a lifetime ban on a former special government employee from representing anyone else before a court or agency in a specific party matter that the SGE worked on while with the government. It's commonly referred to as switching sides, and people get very excited if people leave the government and go outside and represent other parties in connection with

matters that the employee worked on while they were with the Federal government, and this applies for special government employees as well as for regular employees.

The -- there are other restrictions for -- that apply to regular employees. You'll hear -- sometimes you'll hear of two-year -- a two-year cooling off period for government employees who have supervisory responsibility, or one-year cooling off period for senior employees. A one-- the -- the latter, 18 U.S.C. Section 207(c), one-year -- prohibits senior employees from going back to the agency -- their former agency in connection with any matter in which they're offi-- seeking official action on behalf of another person. That is -- that restriction only applies to people who are, as I said, senior employees. Think SES or executive level salaries.

And for SGEs, even if an SGE is paid over the -- the trigger amount for compensation, which is -- my recollection is an annual rate of approximately $136,000 a year -- only if the special government

employee serves for more than 60 days in a calendar year.

There are also restrictions on teaching, speaking and writing. What I want to say first of all, the most important point, is that nothing prevents either an SGE or a regular employee from receiving compensation related to teaching, speaking, writing that the employee does in a personal capacity. The tricky part is sometimes the line between the personal and the official capacity gets blurry. The regulation sets up a number of -- you'll hear the term "relates to official duties". No employee may receive compensation for teaching, speaking or writing that relates to the employee's official duties. That means if it's done as a part of your official duties, you can't receive compensation.

Now I note that that means you can't receive compensation from anybody else. Obviously if you're on the clock, you can receive compensation from the government for the time that you're doing the public's business.

Also if the teaching, speaking or writing draws on non-public information that you acquired through your committee membership, or the invitation was based primarily upon your membership on the committee, the -- or where the invitation comes from a source that would be substantially affected by the performance or non-performance of your official duties as a member of the Advisory Board.

There are also restrictions on gifts that I mentioned earlier in the context of the -- the bribery statute. You may receive gifts that are not offered as a result of your Board membership. However, if you do receive a gift that's given to a Board member because of your official position -- and I will say that in 16 years of Federal service I've never actually received a gift from someone because of my official position; I'm still waiting -- but the -- the -- if that -- if this happens to you, bless you, and -- however, after -- after crowing over your good fortune, you should please consult with the -- the OGC or the

Federal official responsible for the committee, should that situation arise.

Now I want to draw a distinction here between gifts given to you because of your position or achievements in the -- the non-governmental or private sector. Those are generally not problems, and there are a number of gift exceptions that also apply if your spouse has a business and you receive a gift in connection with that. Even -- even if a gift is from a source that would be affected, if it's clear -- for example, if you have a spouse that works for a company that would be affected by something that you do, if the company gives all of their memb-- their employees two tickets to the summer picnic, that's not going to be a problem because it's clear-- although it's from a source that would raise concerns, it's clearly not tied to your position on the com-- on the Advisory Board. It's clearly tied to your spouse's employment. Of course you would be recusing from any matter involving that company anyway, but -- I mention that as an aside -- but there are a

number of exceptions that also apply. And also if there's a situation where you're interviewing for future employment, there are exceptions permitting you to accept travel and other traditional interview-related expenses or gi-- or -- or gi-- or per diems for -- that are offered in those situations.

There are other situations, even -- that -- that are broadly categorized as misuse of position that -- that -- basically these are all derived from the principle that government -- that the public office should not be used for private gain, either on -- by the -- the employee of a special government employee or private gain on anybody else's part, as well. Even if the employee gets no direct benefit, if the employee uses their official position so that somebody else derives an improper benefit, then -- then that's a situation that would implicate the regulation. So there was nothing in it for me is not a defense in this situation.

Basically an important consideration is

that you may not use your position on the Advisory Board to imply either that the Board or the Department endorses your private activities or those of another. You also cannot use your authority as a member of the Board to appear to give a governmental sanction or endorsement to a particular product or -- or company, unless there's specific authority to do so. And in those situations, that's a -- that's the over-arching pattern of my presentation this morning, which is in those situations consult with OGC first 'cause that way we can make sure that all -- that we make -- that -- cross all the t's and dot all the i's, that all the jots and tiddles* are taking place, and it's not going to be a situation that -- that's going to blow up after the fact.

Fundraising restrictions, they -- there's -- again, I want to start out with the -- the broad principle that there's nothing that being a special government employee does that prevents you from doing fundraising for causes you believe in in

your personal capacity. What you cannot do is personally solicit funds from someone who's doing business before the committee or the Advisory Board. And of course in any situation where you have access to non-public information, you cannot disclose that information. That's axiomatic to the term "non-public".

And extension of the criminal statutes is the impartiality principle. And basically all -- all employees are required to -- to ensure that all government decisions and -- and projects and policies are undertaken for -- on an impartial basis, that the decision-makers were considering the -- the government's interests, and by extension, the public's interests in a matter and not personal private interests. And even when it doesn't rise to the level of a conflicting financial interest that would be implicated by 208, these issues still have to be paid attention to under the broad category of impartiality. That's why under the applicable Office of Government Ethics regulations all special government

employees are prohibited from participating in specific party matters -- and the impartiality restrictions deal with specific party matters -- where a reasonable person would question the special government employee's impartiality.

They -- this always leads to the question of whose reasonable person are we talking about. The standard is not well-defined in his con-- connection, except in a -- in a fairly circular fashion. A reasonable person is as a reasonable person does.

They -- so my advice and counsel to the members of the Board are if you're not sure if there would be -- if you have any doubt whatsoever about a question of impartiality being raised, it's better to raise that question with the OGC and get that resolved before it becomes a problem rather than waiting until some stakeholder whose ox has been gored decides to -- to use that as a means of undermining the work of the Advisory Board.

There are certain covered

relationships. Although the principle is not well-defined, there are certain relationships which are set forth in the regulation which are specifically raised as being potentially problematic. These includes (sic) such categories as members of the employee's household, the -- the relatives with whom you have a close personal relationship, any person that the employee or a family member is serving -- your spouse, a parent or a dependent child is serving as an officer, director or employee or consultant, or any situation where a former employer of yours that -- that you served with in the past year, there's sort of a one-year cooling off period, and in that situation you would -- you would want to -- that -- that's a covered relationship. In addition to the employee being able to make a -- make an initial determination, the agency also has the authority to step in and -- and make a determination on whether a reasonable person would question the SGE's impartiality in that situation.

And I'd like to also men-- to -- to specifically talk here about consultancies (sic). A consultant -- any organization that you're serving as a consultant, if that organization is a party or represents a party in connection with a matter, that's an impartiality concern. Please bring that to our attention so that we can get that resolved prior to any action being taken or prior -- prior to your participating in a -- in a specific party matter.

There are also restrictions broadly that apply to all government employees, and these are extended through -- to SGEs, as well. And this is the -- the Constitutional prohibition against receiving emoluments. You hear it referred to as the emoluments clause. Under the Constitution, while holding a position of public off-- of profit or trust with the United States government, you may not have an employment relationship with a foreign government or receive emoluments. Bas-- think broadly in terms of compensation from a foreign government.

Now sometimes the -- the -- this

includes the -- the foreign government directly, and it's -- this is anything that you do in your private capacity. At the time of the drafting of the Constitution, the founding fathers were very concerned about government employees -- the interests of government employees being undermined or their loyalties divided by ties to foreign states and principalities, which is why this clause exists.

A question comes up for public universities in -- in foreign states and -- and the -- the -- or government-controlled companies -- or government-owned companies, and those sometimes can be on a case-by-case basis, depending on the degree of ownership or control that's exercised by the foreign government. We may determine that it's not an emolument issue. But again that's something that would have to be brought to the attention of OGC so that we could resolve that.

Congress has passed an exception to this under the Foreign Gifts and Decorations Act. Generally you can accept a -- gifts

worth up to 200 -- approximately $285 from a foreign government without triggering the restrictions of the emoluments clause. And as part of your -- your packets you probably received a -- you should have received a questionnaire on foreign entanglements, and that's -- that was intended to address and -- and -- I'm not sure of the exact name -- I see laughter in the committee. I'm not sure of the exact name of -- of -- of the form, but it -- it was designed to -- to determine whether committee members have ties to foreign governments so that we could resolve those in advance.

I will say that this pres-- this restriction is -- although a longstanding one, is currently being re-examined by the Department of Justice. And it is possible -- highlight the use of the term "possible" -- that it may be determined by -- by the Department of Justice that the -- the -- an advisory committee membership is not considered an office of profit or trust with the United States and therefore the emoluments clause would not apply. I stress

that we're not there yet. They -- and that's the Department of Justice's call, but there may be some relief on the horizon from that particular restriction.

Expert witnesses, serving as an expert witness, the -- and this is tied once again to matters -- to -- that you work on as a member of the Advisory Board. You may not participate as an expert witness in connection with a matter or proceeding that you work on as a government employee. It's -- I like to think of this as switching sides during the fact as opposed to after the fact. Like 207, it applies while you're still serving as a special government employee. There is a provision set forth in the regulation of getting -- basically you can do it if you get the government's permission to do it.

They -- there are also restrictions that apply in the area of lobbying. And -- and I apologize for this particular slide which has a particularly large amount of text on it, but the -- the -- the information in there is important.

Committee members are prohibited from engaging in any activity which directly or indirectly encourages or directs a person or organization to lobby one or more members of Congress. That's in your official capacity as an Advisory Board, so what we don't want to see is the Advisory Board issuing leaflets to people in the community to go call their Congressman or representative to get a law changed or a particular -- or a particular policy overturned. The Congress doesn't like it when the Executive Branch does that. Congress doesn't really want to be -- want to have a -- see that -- the money that they've appropriated for the committee be used for a lo-- you'll hear the term grassroots lobbying, and that's what this restriction is designed for.

I note that like the other statutes mentioned in Title 18, this is a criminal statute, so attention must be paid to the extent that the potential liabilities are fairly severe. When authorized, committee members may before -- appear before -- this does not prevent you from appearing before a

group for the purpose of informing or educating the public about a particular policy or legislative proposal. If you're not sure in a particular situation, call OGC and make -- and that way they can vet the contents of the lecture and make sure that the Department -- the Advisory Board or you are going to get into hot water over -- over a statement made to an organization.

However, what it does not prevent is you serving -- as private citizens, expressing your own personal views. You can't express the views of the committee as a whole or the views of the Department, but you can express your own private, personal views. In doing so you can state the fact that you're affiliated with the commit-- with the committee or the Advisory Board, and you can state the -- the Board's position -- the Advisory Board's official position on a matter, to the extent that you don't use non-public information. But you can't represent your views as those of the -- the Advisory Board. You cannot take new positions or represent those views as the

positions of the committee or the Advisory Board on the matter. The -- and I would also -- as with other sort of general restrictions, in presenting your own personal views, you can't use government computers, copiers, telephones, staffer resources or other -- letterhead or other appropriated fund-- matters that are paid for by the government. If it's a personal activity, that's fine, but it has to be done in off-duty time. They...

In addition to lobbying, there are also restrictions on Hatch Act or political activity. Now these restrictions are actually -- in the 1990's they were loosened for most Federal employees. And for SGEs, as long as you're even remotely sophisticated, this will not be a problem. The Hatch Act restrictions apply only during the period of any day in which you're actually performing government business. They -- so -- and the example used is that if a special government employee attends a com-- advisory committee meeting in the morning -- from 8:00 in the morning till

1:00 o'clock, and then travels up to -- to Capitol Hill, if the advisory committee were taking place in the Humphrey Building at HHS, it's two blocks to Capitol Hill. You go up the hill so you can attend a political fundraiser or even solicit political contributions from the attendees, that's fine. It's understood that as a special government employee your Federal role is a very limited one.

I note that where -- where we would get into trouble is if you see a fellow Advisory Board member picking up their cell phone during the course of a meeting and starting to make political telephone calls, please discourage them from doing so. They -- and I will say that there are some Hatch Act restrictions that -- that will apply during -- at any time that you're -- that you are a special government employee.

You cannot at any time use your government office or authority to affect an election or undert-- or as -- as a means of coercing a political response out of -- or funds out of an entity or organization. But

so long as you're clearly not doing it in a way that's tied to the Advisory Board, then the -- the political activity restrictions will not apply in that situation.

The -- I'll turn to the last slide, the -- the blessed last slide of our pres-- my presentation this -- this afternoon. I thank you for your time and attention. The most important message -- as I said at the very outset, you have -- all these restrictions I talked about are -- are -- are covered in more detail in the handout that you've received in connection with the meeting this afternoon. Also, if you're not sure about a situation, if there's a wart on the end of your nose, then please bring that to the attention at OGC through David Naimon's shop, and they will assist you in resolving a potential conflict before either another -- a stakeholder or another committee member or another -- an outside entity creates a problem for the Advisory Board and for the decisions and policies of the Advisory Board by launching an attack on you and on the Advisory Board and on the

policy on ethics and conflicts of interest grounds.

I do have a couple of minutes before I have to -- to run back and catch a flight, so if there are specific questions about the -- the areas -- now I will say I will not get into a particular member's situation while standing at the podium and being transcripted (sic) in connection with this meeting, but I will in -- deal with questions generally about the conflict of interest statutes or regulations if the -- the Board has them.

**DR. ZIEMER:** Thank you. Let's open the floor for questions.

(No responses)

**MR. CONDRAY:** I see you all spellbound by my eloquence and therefore I shall yield the podium.

**DR. ZIEMER:** Let me ask --

**MR. CONDRAY:** Oh, we do have one question.

**DR. ZIEMER:** This has to do with recusal, and we generally -- we have an operating rule here that if we're voting on

a matter that deals with a facility -- for example, one of the national labs, we had a vote earlier on -- this -- this is sort of specific for purposes of illustration, but we were trying to prioritize which -- I think it was which -- which site profiles we would review first, and individual -- individuals from particular sites then did not vote on their site or about their site or for their site or against their site, actually.

Now where you talk about stepping out of all proceedings concerning a matter -- for example, we talked here this morning about a couple of sites that were not providing sufficient information, and we have individuals from those sites here. Now is -- is -- is the real rule only directed toward issues if that individual has financial interests or what does financial interest mean? I mean if they work there, they're getting paid.

**MR. CONDRAY:** In a situation -- you remember the financial interests, it's the financial interests of employee, the

financial interests of an -- the -- any attributed financial interests which include, generally speaking, employer's interests, those interests of a spouse or a dependent child, or an organization that you're serving as an officer, director or -- or consultant or -- or trustee.

Now in a situation where you're talking about a particular facility, as a policy that makes a lot of sense because it would be very difficult for me to imagine a situation -- there are any number of ties that would be implicated in a situation where a member of the Advisory Board was associated -- was affiliated with a particular site. And where -- and in -- in that situation, the -- the recusal or disqualification would be a broad means of dealing with all of those conflict of interest concerns.

Now where I thought you were going with this question had to do with what -- the requirements of recusal or disqualification, which would include -- and I will say that if the Board is in a public meeting, you

don't actually have to leave the room in connection with that because the information that's being discussed is public. It's -- however, if the meeting is in closed session, then -- in order -- in order -- then in order to properly consider yourself recused or disqualified and to make sure that you weren't picking up -- didn't have access to information that you shouldn't have access to because of your -- the -- the conflict of interest concern, in that situation the -- the member should leave the room. But the -- the -- in a situation where you're talking about dealing with a specific location, there's so many different kinds of ties that would require recusal or disqualification that -- that -- that it's hard for me to -- to address a specific one other than to say that it would be hard for me to imagine a situation where a recusal or disqualification wouldn't be appropriate for -- for a Board member who is affiliated with a particular site.

**DR. ZIEMER:** Does the reclu-- recusal --

**MR. CONDRAY:** Say disqualification.

**DR. ZIEMER:** -- part includes not only things like voting on some issue, but even the discussion of it. Is that correct?

**MR. CONDRAY:** That's correct.

**DR. ZIEMER:** Yes.

**MR. CONDRAY:** The -- the participation includes providing advice or recommendations, as well as having a part in the specific decision.

**DR. ZIEMER:** Other comments or questions?

(No responses)

**MR. CONDRAY:** Thank you all very much.

**DR. ZIEMER:** We thank you for being with us today, John, and appreciate your input.

**REPORT ON QA/QC OF THE PHONE INTERVIEW PROCESS**

Next on our agenda is a report on the QA/QC process for the phone interviews, and that will be presented by Richard Toohey from ORAU.

**DR. TOOHEY:** Okay. Can you hear me okay? Let's go ahead with this. What I thought it would be good to do on this one -

- talk a little bit about our task four, which was originally called CATI, Computer-Assisted Telephone Interviewing. But we renamed it claimant contact, because it includes a lot more now than just the telephone interview process. So I'll go over the first bit fairly quickly. You're probably already familiar with it. And then get into the meat of what you wanted to hear about today which is the quality assurance and quality control we apply to this process to make sure we are capturing the data that the claimant provides in the interview, and then making sure those data are applied to the dose reconstruction.

So we have numerous responsibilities, and like so much else of this project, they have increased as time has gone on. We essentially handle almost all the mailings to the claimants now except the initial acknowledgement of receipt of the claim. But the introduction letter introduces ORAU and tells them we will be contacting them to schedule the interview.

We conduct the initial interview and

technical review of that. A -- not a transcript, but a report of the interview is mailed to the claimant, and then the claimant's comments on that -- whether written on the report or provided telephonically -- are then captured. The report is updated as necessary.

A lot of the information we capture from the claimant on the interview are simple demographic things -- addresses, phone numbers, things like that -- and we automatically get those into the NIOSH database system, so they are captured. In some cases where the claimant wants an authorized representative -- typically one of their children or in some cases an attorney -- to represent them in this process, we'll mail the forms out, get those back. If we're unable to contact the claimant to schedule the interview, a registered letter goes out that just says hey, we've tried to contact you, we've been unsuccessful. We'd like to have this interview. Please call our toll-free number to schedule it.

Also if the claimant declines the interview, there is a letter goes out to them confirming that they declined the interview, and that's again captured in the analysis record.

As was mentioned, the dose reconstruction introduction letter goes out to the claimant, which primarily provides a list of possible dose reconstructors who will be working on their claim and asks the claimant do they object to any of these people on the basis of potential conflict of interest. And of the 6,000 or more of those that have gone out, we've only had two come back from the claimant saying no, I don't like this person. We've had many more -- well, many more; four or five -- come back from the claimant specifically requesting the conflict of interest rule be waived because they would prefer somebody from the site who knows something about the site to do their dose reconstruction. Again, we get back to them saying well, sorry, we're -- really it's better if we don't do that. But we do also say we do have people

knowledgeable about the sites contributing to the site profile and the exposure conditions on the site, things like that.

Any additional data or information the client sends in and anything they have that they want to send in and add to their file is fair game. We receive that and scan it in, make it -- sure it's part of their record.

Something we just took over at the beginning of the year was conducting the closeout interview with the claimant, and this is after the claimant has received their dose reconstruction report and the OCAS-1 form. We simply call them and ask them do they have any questions about it.

And if there's been a delay in returning that OCAS-1 form, we ask them if there's a problem, are you willing to send it back -- explain what it means. And the one problem we've seen -- and like many others, it -- as you know, this is a very complicated, involved process and can be confusing. The OCAS-1 form simply is the claimant's agreement that they have nothing

more to add to their file, no other information, no other documents, at this time. It doesn't mean they agree with the conclusions of the dose reconstruction report, which many of them think it means. So again, in the closeout interview we try to make that clear, and sometimes we're successful and sometimes we're not.

Any additional information provided by the claimant -- and that might be an incident report or something. There have been a number of cases in the interview process where the claimant has acknowledged involvement in an incident, and then we have gone back to get -- try to get the incident report, if any, from DOE, if it was not already in the claimant's data submittal.

We of course do the scheduling of all interviews. Another point on that, one number -- one reason the number of phone calls you saw on Jim Neton's presentation was so high, it typically takes a couple of rounds of telephone tag to schedule the interview. We will call people. If we don't reach them, we'll leave a message.

They call us back, so it takes about three or four calls before we're actually connected with the claimant to do the interview. A lot of times the -- many of our calls, of course, are requests for status of the claim -- from the claimant, as you might imagine.

Our staffing in task four is 33 people. We have -- two of the interviewers are half-time, so we have a total of 32 FTE, so half of those are people -- well, more than half are actually doing the interviews, and we have a late shift. We have a couple of people work into the evening, 8:00 or 9:00 p.m. eastern time, give us a better chance of catching people on the west coast. And a couple of 800 operators man the line, and then schedulers, reviewers, clerical staff handles the mailings, and some supervisors.

So I'll go over these statistics fairly quickly. One reason -- I have to apologize, when I put these together, for once I put my slides together in advance of the meeting, so all I had were the April numbers and Jim Neton gave you the more updated ones, but

just to synchronize things, as Jim showed, through the end of May we've done about 14,400 interviews -- well, no, I'm sorry, 14,400 claims have received at least one interview. And we've only got about right now 1,200, 1,300 claims awaiting interview. The one statistic is -- it's an average of about 1.33 interviews per claim or per Energy employee, because every claimant -- if there are multiple children with no surviving spouse, all the children are claimants, they each get an interview. So it's about one-third more interviews than there are actual claims in there, but we've knocked most of them out. As you've seen, we're averaging about 300 a week and our maximum was close to 500 one week, but there was a lot of overtime involved in that.

The closeout interviews, as I mentioned, we took over in January and we've completed about 3,300 of those. Again, it's with every claimant, so again that's an average about 1.33 per dose reconstruction. OCAS was doing those initially, transferred them over to us beginning of the year.

We've done about 2,000, and we're averaging about 105. And of course, as I hope is obvious, as we complete the backlog of initial interviews, the interviewers are transitioning over doing the closeout interviews, plus any interviewing or information-gathering that may be necessary for SEC petitions that come in.

On the 800 operations, again, that's about 3,000, 4,000 calls a month come in. The vast majority of them are the status of the claim. You know, where is my claim in the process, how long is it going to take, that sort of thing. People do call in changes in addresses, phone numbers, things like that. Frequently, though, children will call in where the claimant has in fact passed away. And then unfortunately, that almost kicks them back to square one since then the survivors have to refile the claim with DOL. Any updates they have to their interview or -- or requests for information that we can give them. This has down-trended over the last year as more information's been put up on the NIOSH web

page, so... But it's pretty steady.

We send out a lot of mail, as you can see. And then a copy of every letter to a claimant is entered into their claim file in NOCTS, and we also have pretty automated capability now. If NIOSH needs to send out a mass mailing for some reason, we can generate that letter and get it out in the mail pretty quickly.

Okay, let's get to the meat of things, QA on this process. One of the first things is training of the interviewers. The interviewers, the health physicists who review the interview reports and -- and the one -- they should really say -- it should probably be a QC person within the task. QA is the loftier organization who makes sure the QC people are doing their job. They get telephone skills training, how to talk to people on the telephone, and especially talking to elderly people, who form the majority of the claimants or may have hearing difficulties or the like. They get an overview of the Act and the DOE facilities and what went on at that. Many

of the interviewers have worked at DOE facilities, particularly Mound and Fernald in the Cincinnati area. But some had not, so we got everybody up on what them and what the Act is about.

We give them what is the equivalent of general employee radiation training under the DOE package, which is the introduction to radiation, protection concepts and all that, just to give them the basic vocabulary of the business so they know what the claimants are saying or referring to in that. And then before they actually get cut loose to do interviews, there's extensive on-the-job training. And they will do several interviews which are monitored by a supervisor, from which they get immediate feedback, before we certify them to cut them loose.

The people who are not so much directly involved in doing the interviews themselves, of course, get the telephone skills training and on-the-job training. I should mention, it's not listed here, but everybody in -- on the ORAU team gets Privacy Act training,

also, and it's one of my pet peeves. I keep emphasizing, you know, this is Privacy Act data. You can't leave it lying out on your desk. You can't take it home with you. You can't talk to your -- your spouse about that and everything else, so everybody gets that.

Okay. We maintain a database on the telephone interviews, and these are basically QC things. There are automatic checks run on a daily basis on that to make sure we don't call a claimant to schedule an interview with them before that letter's gone out to them that says hey, we're going to call you to schedule your interview. We don't do an interview unless it's already been scheduled and -- and is on the calendar. We also check to see after the interview that the initial draft to the claimant is on its way back to the claimant within a week. The same thing on any updates that the claimant may provide on that draft for a revision. We also track that we haven't missed a scheduled interview. We won't do a closeout interview unless there was an initial interview done.

Obviously that would be cart-before-the-horse. And we also check to make sure we don't try to schedule a closeout interview unless the draft dose reconstruction report and OCAS-1 has actually been sent to the claimant.

This is all automated and just pops up. We use Microsoft Outlook to schedule the interviewer's time, and whenever an interview is scheduled, there's an automatic check run against this thing and so on.

The other automatic queries are to make sure that any correspondence that's mailed to the claimant is in fact automatically uploaded to that claim file, and that the dates on the correspondence match those in the database. And again, this is creating the -- what is now called the analysis record for the claim, which then accompanies that claim back to DOL when we've completed the dose reconstruction.

General QA on this, we do silent monitoring of both initial and closeout interviews by supervisory staff. Generally it's performed randomly. The opening part

of the interview -- the interviewer will tell the claimant that this telephone call may be monitored for quality assurance purposes. You know, same thing you hear when you call up Delta Air Lines.

The interviewer can also request monitoring, and in fact on their computer screen in front of them while they're going through the CATI script and entering the claimant's data, they've got a little button they can hit which will signal a supervisor to get on the line. And basically if the claimant has raised some issue that the interviewer hasn't a clue what they are talking about or what it means or what's going on, they can get a health physicist on that line to help them with that, essentially instantaneously. The HP reviewers are assigned blocks of time when they have to be available for this.

The comments that the monitor has are entered actually into a spreadsheet, so a poor man's database. There is immediate feedback to the interviewer via e-mail, what you did good, what you did bad, areas for

improvement, whatever like that. Anything that would identify a group trend, some ongoing problem with that then gets addressed on a group basis in weekly staff meetings of task four. The -- of course the feedback to the interviewer is immediate and generations of lessons learned and, as I said, the interviewer can be assisted with difficult claimants or questions. And of course, as you can imagine, because the long time it's taken, many of the claimants are -- are upset, why is it taking so long. And like most of us, they say let me talk to your supervisor. Push a button, the supervisor's on the line.

Okay, there are the, as I said, weekly staff meetings and interview sessions to discuss how things are going, new approaches, issues that have come up, improvements in the software. We did roll out a new and improved version of the CATI software a few months ago.

We have put together some quick reference guides for the interviewers, just kind of checklists to make sure they have

covered all the bases in the interview process. And there's dual screens. Each interviewer has a dual computer screen and one has the CATI script on it, the other has sort of this checklist thing so they can keep track that they've covered all the bases.

Another thing we do, any claimant who calls in saying they've had a problem or an interview with any of that, their calls are -- normally those calls come in to the 800 number. They're logged in and then returned by a supervisor to find out what the issue is, and they get logged and tracked. And I should also say every call that comes in is logged in to the NOCTS database in the telephone conversation file in there. And then of course tracking these things gives us individual and group metrics on their performance.

Some of the challenges we have encountered is contacting claimants. As we know, a number have passed away in the meantime. People leave the country on vacation. We've got a lot of snowbirds.

You know, we try to call people from Hanford, and they're in Arizona, you know, gone to Florida. There've been a few we haven't been able to contact because they're in the slammer. It happens.

The closeout interviews on a dose reconstruction where the probability of causation was less than 50 percent, by now people know what that means, that they're likely not to be compensable. So there are issues in there. And as I said, especially in those cases, there's difficulty in convincing the claimant to return the OCAS-1. And again, we try to explain it in any number of ways we can. Now all -- it just says you don't have anything to add. If you do, put it on and send it back in; we'll capture it and start over. But there are a number just refuse to return it. And then as Jim Neton mentioned, after 60 days there's an administrative closeout in there.

And of course ability to communicate with elderly or emotional claimants. Another small issue we have -- in a lot of cases a claimant would want a -- a son or

daughter to assist in the interview, but we really can't do that unless they're designated as an authorized representative, so we have to send that form out and get it back in and all that sort of stuff. But it -- it's not a real big problem and we have a way to handle it.

So we're -- OCAS is still mailing out the draft dose reconstruction reports. We'll probably be taking that over for them, and then getting ready to go on the Special Exposure Cohort process. And exactly what sort of workload that's going to be on us is, at this point, anyone's guess.

I didn't mention -- perhaps I skipped a slide, but let me just go over a few things. On the draft DR report, it is reviewed by a health physicist reviewer. They have a checklist they work against for things like accuracy of terminology, issues, work processes and any of that thing, as well as spelling, grammar and everything else before that goes out.

We get about one-quarter of the draft reports back with comments on them that --

and the vast majority of those are additions. Again, as you might expect with an elderly population -- oh, I forgot to mention that, and they write it down and -- you know, that's what the whole process is, then that is captured and added to the case file. And a lot of times I think, as was mentioned earlier by Jim, we get information on additional work history -- you know, I worked at site A plus site B. Well, it's not in their records and then that means we have to -- unless they were likely to be compensable on the data we already have from site A, we have to go get records from site B, and of course DOL has to verify that, additional cancer diagnosis, things like this. So there are a number of issues that can crop up in the interview process which move the process back to the verification of employment/diagnosis stage. But there's a process to handle that.

So really the primary quality control on the draft DR report is by our reviewer, and then by the interviewee themselves.

Then the other issue on using the

information in the CATI report in dose reconstruction, that report is in the dose reconstruction file that the dose reconstructor references to use. They are required to review it. There are re-- there is required verbiage in the dose reconstruction report that says I have reviewed the information in the interview and however it was used. And as I said, a lot of times the -- the information that comes out in an interview is I was in an incident of some kind at some time. And then we have to go track that down, and hopefully we can find enough information and apply it in the dose reconstruction itself. And then of course the check that the interview information has been used in the dose reconstruction report is our own peer reviewer who reviews the DR report before it goes to OCAS, and the OCAS reviewer who approves it before it goes out to the claimant, and then the claimants' review of it themselves.

And again, we found a feedback loop that once the final DR report has gone out,

claimants will then add additional information to that, send it back in and, again, we fold that back in and redo the report as necessary.

So let me just check here, I think that's all I had formally, so -- ah, one -- one more thing, just a -- the procedure list. We have three procedures in place. The fourth one is the checklists used by the reviewers. And the only reason that's still in draft is when it went through internal review, the QA people said oh, this is really a quality procedure and you should put other things in here to qualify it as such under some criteria they have, so we're putting that in. But that will be out fairly quickly and over to OCAS for their approval.

Okay, so that is it. So I'll be glad to attempt to answer any questions you may have.

**DR. ZIEMER:** Thank you. First Roy and then Jim.

**DR. DEHART:** I have two questions. First, we have talked in the past about the

possibility of having assistance for some of the older people, and is there any attempt to encourage them to have coworkers or anyone there during the interview, sort of as a mind kick-off to help hit -- get the memory hooks going or anything of that sort?

**DR. TOOHEY:** Gosh, I don't think there is on our end up front. If they bring it up, then yeah, they can have anybody they want there while we capture that data, but they can't have somebody actually do the interview for them, unless it's an authorized representative.

**DR. DEHART:** I understand that, but I was --

**DR. TOOHEY:** Do we go out and actually tell them up front -- oh, you can bring people? I don't think so. Jim?

**DR. NETON:** (Off microphone) We don't do that, but we do send them a copy of the questions they're going to (Inaudible) in advance, so they have the opportunity to go over all the questions and talk to as many people as they need to (Inaudible) refresh their memory (Inaudible) answers

(Inaudible).

**DR. TOOHEY:** Actually where I mentioned that before, if there's a local advocacy group, they help this quite a lot.

**DR. DEHART:** That's -- that's my point. I just wondered if we're encouraging them to take that step as we prepare them for interview.

**DR. TOOHEY:** Not per se. And in fact the one problem -- most of -- we're getting very few complaints, but most of the ones we are, which you've heard before, primarily from survivors -- I don't know the answers to any of these questions. And again, they have the opinion that they have to provide the data and their inability to answer these questions will adversely affect the dose reconstruction. Again, we try to assure them no, that's not the case. We rely on DOE or other sources to get the data. This is just to help us capture anything you might have.

**DR. DEHART:** It might be worthwhile taking the initiative to suggest that there -- if there are others -- advocacy groups,

coworkers, whatever -- that your father used to work for -- work with, maybe you could help them -- have them help me go over these questions that I know I'm going to ask.

**DR. TOOHEY:** Sure. I know there have been a number where that has been the case.

**DR. DEHART:** I would think that that would --that would be helpful, as I think over my own past experience it would be helpful to have somebody remind me.

The other question -- I'll wait to see if Jim hits it.

**DR. ZIEMER:** Jim.

**DR. MELIUS:** The pressure's on. Well, I have three -- can I get three, just so I have three tries to get your question in.

My first question is, how long for the interviewers -- you talked about their training. How long is the telephone skills training?

**DR. TOOHEY:** You know, off the top of my head I don't know that. I'll take a whack and say it's at least one hour, maybe two. That does include some role-playing, practical, back and forth.

**DR. MELIUS:** And how about the DOE facilities training?

**DR. TOOHEY:** That is, again, two to four hours. I can -- I'll find these out exactly and get it back to you because all these training packages are, you know, available.

**DR. MELIUS:** Yeah, that would --

**DR. TOOHEY:** In fact, if you want to see the training materials, I can shoot you a copy.

**DR. MELIUS:** I'd like to see the (Inaudible), particularly the one that's under review, the process review of telephone, once -- I guess once OCAS -- once Larry's approved it or whoever has.

My second question is what percentage of the interviews are you listening in on?

**DR. TOOHEY:** It's not that high. It's only about one percent.

**DR. MELIUS:** Okay. And my third question -- or questions -- relate to how you're recording this information when there's a problem. You said you had sort of a -- fairly -- term used -- poor man's

database or --

**DR. TOOHEY:** Oh, it's a -- it's an Excel spreadsheet --

**DR. MELIUS:** A spreadsheet.

**DR. TOOHEY:** -- rather than calling it a database.

**DR. MELIUS:** How is this dealt with systematically? And along with that, there seems to me -- and Tony, you may remember when we went through this process, there were some other points along the line where possible problems with the interview could be discovered. For example, when the health physicist was actually doing the --

**DR. TOOHEY:** Oh, yeah.

**DR. MELIUS:** -- dose reconstruction. Well, if that occurs, is that recorded in any way --

**DR. TOOHEY:** Yes.

**DR. MELIUS:** -- reviewed, and is there any systematic...

**DR. TOOHEY:** Yeah, that's actually captured in what we call our claims tracking to where the individual dose reconstructor, if they see an issue in the interview report

that they think they need more information, it can kick it back either to try to get more information from the claimant or what -- also what the health physics review within task four tries to -- if it looks like it's a systemic issue, say an incident report -- do we have anything on this, do we know anything about -- they'll kick it over to task three, which is the dose reconstruction research group to see if there's anything on hand already on that or if we need to request it. And if it's say a site-wide issue, if it's -- needs to be addressed in the site profile, so there are feedback loops that'll --

**DR. MELIUS:** Are you -- are you capturing those when they occur so there's some sort of a review of the overall process and a determination that -- to what extent these problems might be due to an interviewer --

**DR. TOOHEY:** Uh-huh, yes.

**DR. MELIUS:** -- not doing their job; secondly, the interview itself not being -- you know, asking the right questions or --

**DR. TOOHEY:** Right.

**DR. MELIUS:** -- asking -- being misunderstood, et cetera.

**DR. TOOHEY:** Yeah, so --

**DR. MELIUS:** And how many times is it, you know, due to the -- the -- you know, the claimant can't remember, you know, doesn't have the information, so forth. Seems to me that would be -- if we're ever going to, you know, improve and maintain this process properly that that kind of information and the feedback -- and I guess I was a little disturbed that all this was left out of your presentation today, if it is occurring.

**DR. TOOHEY:** They are all captured.

**DR. MELIUS:** And reviewed? Is there a report or some way that we -- something we could see that would illustrate that?

**DR. TOOHEY:** I don't see why not.

**DR. ZIEMER:** I guess that's a yes.

**DR. TOOHEY:** Well, okay.

**DR. ZIEMER:** Okay.

**DR. MELIUS:** Well, since he doesn't -- since -- have any details, I'm not sure what I'm asking for, but whatever you have, I

guess I'd like to look at.

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

**DR. DEHART:** Dr. Melius touched on what my second question, as I thought he might. I would broaden the question. You have QA throughout the whole process that you were describing, what you're looking for and checking. I think we would like to see the data dump on that. In other words, how many times are you checking QA item number one and what's the results of that. You indicated that you're looking at it, but you didn't mention that you're doing it 50 percent, 100 percent, or there's a concern in management.

**DR. ZIEMER:** I'm not sure that was a specific question, but it was a clarification, certainly. Did you have --

**DR. DEHART:** The question would be to acquire the data so that we could see it.

**DR. TOOHEY:** Basically you want some data mining --

**DR. DEHART:** Yes.

**DR. TOOHEY:** -- out of that database.

**DR. DEHART:** Sure.

**DR. ZIEMER:** Okay. Dr. Roessler.

**DR. ROESSLER:** In doing your QA and looking at consistency of interviews across the board, I could picture these people who are doing this day in and day out maybe getting kind of bored or tired at the end of the day or at the end of the week or at 3:00 o'clock when you need a cup of coffee. Have you seen any kind of pattern and, if so, what -- what do you do about it?

**DR. TOOHEY:** Actually we haven't. The pattern has evolved that some people have said I've had enough of this, I want to do closeout interviews. And other interviewers have said no, I really enjoy this, I want to keep doing this. And we've winnowed out the ineffective interviewers. Fortunately there's only been one or two on that since we started. I expected we would need a revolving door on the CATI facility when we built it. Nobody's -- two people out of the 30-odd have quit in the almost -- well, year and a half we've been working this. So they enjoy what they're doing and the -- the review of the draft interview report, you

know, the questions have been answered and filled in properly, the -- you know, checklists are -- have been used and marked off. It's there. So we haven't really noticed much slippage in quality, and I'm just as amazed as you are.

**DR. DOOLEY:** Dick, I just wanted to add one thing to Dr. Melius's question.

**DR. ZIEMER:** Yeah, you'll need to identify for the --

**DR. DOOLEY:** Yes, Dave Dooley with the MJW Corporation. We actually take about three weeks to get a CATI interviewer up to speed. Yeah, there is formal training of an hour or two, but before they're up and on their own and on their own, it takes about three weeks to get them up and trained before they're doing interviews on their own, so it's not -- it's a little bit more than a one-hour process.

**DR. MELIUS:** Thank you, that --

**DR. TOOHEY:** Well, the -- actually the formal training's about two days on everything, and then we'll give you that. But then the on-the-job training does extend

over a couple of weeks before they're turned loose.

**DR. ZIEMER:** Mark and then Robert.

**MR. GRIFFON:** I guess -- a couple of questions, and the first one's a little broader. I was just curious how -- from the -- from the cases that you've completed, the dose reconstructions you've completed, have you found interview data generally to be useful, to be -- to influence the dose reconstructions?

**DR. TOOHEY:** The -- we -- well, when we do a triage or maybe a biage (sic), if it's a survivor claim, generally you get very little, if anything, useful. When the interview is with the Energy employee themselves, what -- the primary thing that we've captured and have used in dose reconstruction have been incident reports. As -- a lot of times incident reports are not in the DOE submittal, even though they're requested, because at some sites they're filed separately. You have the workers' radiation monitoring data, which is sent in. But any incidents that worker was

in, they're filed completely separately and they're not cross-indexed. And a lot of the reports aren't -- don't even have worker names. It's worker A, worker B, worker C in this incident report. So what we do from the worker is get, you know, date, location, type of incident as best we can, and then with as much information as we have, we send a supplemental request to the site for an incident report on that. Or in some cases we may already have it. We go through the database. Yeah, but there have been a number of those where incident reports have then been found and added into the dose reconstruction. I can't tell you what percentage off the top of my head, but that -- that's the primary thing we get that influences the dose reconstruction, aside from what I'll call DOL type data, which is employment history or cancer diagnosis.

**MR. GRIFFON:** Okay. And then have you -- I think I might have brought this up earlier. I probably did bring this up at another meeting, but have you developed any sort of templates for the interviewers that

might assist them in site-specific terminology? I know we talked about a site-specific addenda questionnaire which was out of the question because of OMB process --

**DR. TOOHEY:** Yeah.

**MR. GRIFFON:** -- but -- the reason I ask this is because these people don't know isotopes, generally speaking, but they do know trade names or -- or code names or things like that --

**DR. TOOHEY:** (Inaudible)

**MR. GRIFFON:** -- right, exactly.

**DR. TOOHEY:** Yeah, we do have a glossary of that. It's not -- it's sort of complex-wide. It's not site-specific.

**MR. GRIFFON:** Okay. So they -- they do know those.

**DR. TOOHEY:** Yeah, it's basically the terminology --

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

**DR. TOOHEY:** -- familiarization for the interviewers.

**MR. GRIFFON:** And that is not included in any way with the questionnaire to trigger their memories or anything like that --

probably not.

**DR. TOOHEY:** No.

**MR. GRIFFON:** No. Okay. And I think this might be my final question. Are you looking at this data in aggregate in any way? Are you looking -- are you putting the questionnaires into any kind of database and looking -- by site? For instance if, you know, I'm -- I'm going to the coworkers step. I don't know --

**DR. TOOHEY:** Oh, for site trends.

**MR. GRIFFON:** -- if this is being --

**DR. TOOHEY:** Not yet.

**MR. GRIFFON:** Yeah, for site trends or --

**DR. TOOHEY:** Not yet, but that's on the agenda.

**MR. GRIFFON:** On the hor-- okay.

**DR. TOOHEY:** Yeah, because -- you know, when we discuss using coworker data, there's really two sets; these huge volumes of site data gathered for previous epidemiology studies, and then there's the dose reconstruction data for claimants from the site. We're building that -- I think now we

call it the job exposure matrix off the completed dose reconstructions, which includes those interviews.

**MR. GRIFFON:** Okay.

**DR. TOOHEY:** But you know, a couple of thousand finals on hand, we haven't really started mining that yet to look for site trends.

**MR. GRIFFON:** All right. And one -- I think one final question. Do you do any kind of classification description at the front of your interview?

**DR. TOOHEY:** We don't initiate it. Many times the worker will say well, I can't discuss this; it's classified. And we have a script for the interviewer to follow which is well, none of the questions we're going to be asking should involve classified data. If you feel the information you want to give us is classified, then we make arrangements for a face-to-face interview by a cleared person in a secure facility.

**MR. GRIFFON:** Okay.

**DR. TOOHEY:** We have done dozens of those.

**MR. GRIFFON:** The other -- the other thing, my experience is that it was helpful for us to have -- we actually had classification people from the sites come in and do this and tell group -- groups that we were interviewing that, you know, you worked here 30, 40 years ago. Classification rules have changed, a lot of things have been declassified, and you can talk about these.

**DR. TOOHEY:** Well --

**MR. GRIFFON:** Otherwise they may never tell you on the interview --

**DR. TOOHEY:** Exactly.

**MR. GRIFFON:** -- but they're storing this information and --

**DR. TOOHEY:** Well, and we found that in the supposedly classified interviews we've done that then those reports are reviewed by -- by an ADC on the site and there, to date, have not been any classified data actually provided by claimants. But as you say, in the intervening 30, 40 years, it's been declassified.

**MR. GRIFFON:** Right. My point is to -- to --

**DR. TOOHEY:** Yeah.

**MR. GRIFFON:** -- I guess in sort of a more proactive way to sort of say it's okay to talk about most of this stuff or -- or -- I don't know how --

**DR. TOOHEY:** I don't think I'm going to stick my neck out that way, but I'll be glad to, you know, let OCAS arrange it with DOE. See, the one problem with that --

**MR. GRIFFON:** I understand.

**DR. TOOHEY:** -- yeah, and we have discussed this, is -- as you well know -- it's site-specific.

**MR. GRIFFON:** Right.

**DR. TOOHEY:** And then of course trying to do it generically just -- just doesn't work.

**DR. ZIEMER:** Robert?

**MR. PRESLEY:** Dr. Toohey, when the OCAS-1 form goes out -- we've heard two or three people state today that the claimants or people that are filling in for the claimants don't understand what they're getting. Is there a letter that goes out, an explanation letter that goes out with

that that would explain to these people exactly what this is and what to do with it?

**DR. TOOHEY:** I'm going to pass that one to my colleague, Dr. Neton. I think so, but I honestly don't remember.

**DR. NETON:** (Off microphone) Yes, there's -- there's a letter that goes out that explains exactly that (Inaudible) --

**UNIDENTIFIED:** Jim, you're mike's not working. Turn the mike on.

**DR. NETON:** Oh, I'm sorry.

**MR. ELLIOTT:** Thank you.

**DR. NETON:** Yes, there is a letter that goes out with the -- with the OCAS-1 form and the draft dose reconstruction report that essentially says that they are not signing that they agree, that it is they are done providing us information, or something to that effect. It's in there.

**MR. PRESLEY:** Okay. Thank you, Jim.

**DR. MELIUS:** Yeah, two quick follow-up questions and one Jim Neton may talk about later, so it's not appropriate. That's this whole -- this incidents database which is not, as I understood from our last meeting,

is not part of the site profiles but there's this series of documents -- database that you're keeping, so forth. I'm assuming that if during the interview you discover incidents that aren't part of the site profile or not recorded, that gets referred into this system?

**DR. TOOHEY:** Yes.

**DR. MELIUS:** Okay.

**DR. TOOHEY:** When we hear about an incident from a claimant, the first thing to do is we look and see if we've already got the report. If we don't, we go ask DOE for it.

**DR. MELIUS:** Okay.

**DR. TOOHEY:** If they can't provide it, then we've -- you know, try to follow a thread, dig a little bit deeper to find out what -- what actually happened. And sometimes we can and sometimes we can't.

**DR. MELIUS:** But is there any way of recording -- well, what if you can't find it? Is it still recorded in this incidents database in a way that -- what if, you know, another claimant mentions the same -- you

know, you start to see a pattern or something?

**DR. TOOHEY:** The fact that the claimant refers to it is captured. If it -- if it's not in the database, we know what we've asked for, so if we know we can't get it from DOE and it forms a pattern, yeah, that gets kicked back to dose reconstruction research, the people who do the site profiles. And say hey, look at this and come up with it. The problem is, most of what the workers could provide us would not be adequate data to support a dose reconstruction. They may be able to tell you the isotope, but not how much, the form -- you know, duration, things like that.

**MR. ELLIOTT:** Don't forget we also have an affidavit approach that could be employed here.

**DR. TOOHEY:** Yeah.

**MR. ELLIOTT:** And once you have an affidavit and you verify the reasonability of it, then that I think is also added to the incident reporting.

**DR. TOOHEY:** Yes.

**DR. MELIUS:** Yeah, I'm just trying to figure out what this -- this extra database is and how it fits with the site profile, so if Jim talks about it later or as you develop it, if you want to brief us on it at another meeting, that's the most efficient way, that's fine.

My last -- just really a comment to follow up on Roy's first question, this idea of referring people to some of the advocacy or representational groups around, I think that would be particularly helpful for survivors beforehand because, you know, again, they don't all live in the area, you know, there or they may not have -- have the contacts and so forth. And I've certainly been impressed at -- both up here in Buffalo but many other sites that we've been at at how helpful and knowledgeable these people can be in helping, you know, determine what happened to people, where people worked and so forth. And I think having them referred to some of these groups prior to the interviews may actually help make those interviews more worthwhile and -- and

helpful, you know. He wor-- you know, my father worked with this group or -- or whatever. It may be more useful.

**DR. TOOHEY:** Let me add that we're starting to see some of that come back from the worker outreach program where we're presenting the site profiles to organized labor and -- and where there is no remaining organized labor entity, we can address assorted stakeholders.

**DR. MELIUS:** And then I'm just thinking if there's the survivors living, you know, 1,000 miles away, at least they could refer them -- they may not have direct access or hear -- read about it in the newspaper or whatever, but at least would be referred and could be helpful to them.

**DR. TOOHEY:** Actually we've got kind of an initiative to work on that. Vern McDougal*, who's working with us and has good union representative -- a lot of the unions of course have their retiree organizations and mailing lists, and we're exploring ways to help that get some of the word out.

**DR. MELIUS:** Okay, good.

**DR. ZIEMER:** Mike, you had a comment, question?

**MR. GIBSON:** These incident reports that you go back to DOE or -- they're generated by the contractor, most of the time --

**DR. TOOHEY:** Yes.

**MR. GIBSON:** -- and with the inception of Price Anderson -- I mean these fines and everything else -- these contractors vigorously try to downplay the incident and the extent of the incident, the isotopes involved, so how are you depending on that information that you may get from them as being -- trying to develop a worst-case dose estimate?

**DR. TOOHEY:** Well, once I know the isotope and I know something about the characteristics of the incident and the process, I can start making some brackets for worst case. But I would also remind you that the worst-case situation is primarily applicable to a case that's likely to be non-compensable, so we're going to give them

a maximum dose assessment. Other cases we want to actually give them the best estimate of the dose, and that takes more digging. And like every other part of this, the DOE submittal is only part of what we have to consider. There may be independent reviews of claimant input, coworker input and other things like that. And we just take everything into account and do the best we can.

**DR. ZIEMER:** Rich, originally we -- when we learned that you were doing some sort of quality assurance on the telephone interviews -- because we've had an ongoing interest in exactly how those were progressing and so on -- I think that led to this presentation today. It's -- it's an evolving process, obviously, that you're developing the QA/QC parts of this. And we ourselves will probably end up doing some independent evaluations through our audit approach. But there's been several items that have sort of been asked for here. I'd like to -- rather than having many individuals on the Board ask you to provide

different pieces of things, I'd like to try to pin down what it is the Board feels they need as we go forward, in terms of additional information. I think several things have been alluded to, and just so we have it in the record and agree to whatever that we can kind of pin that down and say okay, these things the Board needs or -- or if we don't think we need them, we can say so, but...

**DR. TOOHEY:** I'm ready to copy.

**DR. ZIEMER:** And -- yeah, I think Jim mentioned some things, maybe Roy did and maybe others.

**DR. MELIUS:** I was just going to suggest maybe procedurally if we could reactivate that working group that met 'cause I mean I have my notes from that that might help us -- I mean, Tony, you -- you --

**DR. ZIEMER:** Was that your working group on interviews?

**DR. MELIUS:** On interviews, and if we interact with -- with whoever, Larry and (Inaudible), I think we could probably pull together a request and it just might be more

efficient than trying to go through a list -- - list here, and I think -- certainly I -- I'd certainly be willing to do that if that's a -- would help move this along.

**DR. ZIEMER:** We can certainly do that. I don't recall who was on that working group, actually. Tony was?

**DR. MELIUS:** Tony and I, Richard I think --

**MR. ESPINOSA:** Don't volunteer me. I wasn't on that group. I don't believe I was.

**DR. ROESSLER:** Was it Wanda?

**DR. MELIUS:** I can't -- I don't -- we'll find it.

**DR. ZIEMER:** Well, it does not necessarily have to be those same individuals if -- if two or three of you want to agree to go back and develop some items that you think we need to see. It'll be one thing to say, you know, out of general interest, but some specific things that would be helpful to us in evaluating or even just saying what might we suggest that they consider. We don't -- you know, I

think we can talk about what they might consider as they go forward, also, that might be helpful to their QA/QC process.

**DR. MELIUS:** The reason I think -- I suggested the working group is that we -- it went through and developed a sort of a list of steps in the process and -- and what the QA/QC procedures that were either in place or were planned for those different steps. And I think -- I think they made a significant amount of progress --

**DR. ZIEMER:** And perhaps just look at those and --

**DR. MELIUS:** Exactly --

**DR. ZIEMER:** -- sort of lay it side by side and --

**DR. MELIUS:** I don't think this has to be a very onerous or lengthy task, but I just think it would be more efficient than try -- 'cause I frankly can't remember all the things --

**DR. ZIEMER:** And I don't, either. Tony, did you want to comment on that?

**DR. ANDRADE:** I just wanted to congratulate Richard and -- and the

Associated Universities with the work they have done in that I believe they've implemented just about every suggestion that we did come up with in the working group, and perhaps even more.

However, now that this data collection process has really come together, I think in general what we would like to see are the trends, the issues and the things that come out from looking -- from analyzing the data, so that the data itself is probably meaningless if -- you know, if it's displayed on the screen, but those things that are -- that have been discovered and those things that have come to light as a result I think in general are what Jim and I would suggest for a future meeting.

**DR. TOOHEY:** I think I probably have in my files what I think was a draft report of that working group that we started to work on, then that got dropped for some reason and very -- we went on to other things and --

**DR. MELIUS:** Yeah, I think it got dropped 'cause you were in -- we presented

it at a meeting, discussed it and a lot of stuff was being implemented so it didn't make sense to --

**DR. ZIEMER:** Right, and the working group was ad hoc and in that sense this does not have to be the same identical group. Are the two of you volunteering to participate?

**DR. MELIUS:** Yeah.

**DR. ZIEMER:** Let's get one more person -- Wanda? The three of you then constitute the working group. Who -- do you want to take the lead, Jim, and the three of you develop a report for us at the next meeting then and we'll --

**DR. MELIUS:** That would be --

**DR. ZIEMER:** And if you would -- now I'll simply ask you to review what we looked at before and review what ORAU has been doing, and kind of do a side-by-side and if there's some -- some gaps that we think would be helpful for them to address, that's fine, too. Again, I don't think we want to necessarily be in the business of laying out their QA/QC program, but we want to see what

it is telling us. Okay. And if there's some things that could be mined from the data, that would be great. Okay. So that -- those three will constitute a -- an ad hoc working group to address this issue.

Are there any further comments for Dr. Toohey?

(No responses)

**DR. ZIEMER:** Okay. Richard, thank you very much. We appreciate --

**DR. TOOHEY:** Thank you.

**DR. ZIEMER:** -- as usual your good report to us.

Now we're well past our break time but we will take our 15 minutes.

(Whereupon, a recess was taken.)

**DR. ZIEMER:** I'd like to call the meeting back to order. Before we take our next agenda item, we have with us today one individual member of the public who wishes to address the Board and who will not be able to be here this evening. That individual is Fred Stockwell. Fred is with a group called Steelworkers Organization of Active Retirees, or SOAR, and he's going to

soar up to the microphone there. Would we be better to use a lapel mike for Fred?

**UNIDENTIFIED:** I think we can do --

**DR. ZIEMER:** Can do it there, okay. Fred, welcome.

**MR. STOCKWELL:** Thank you for this opportunity to speak today. I was a steel worker for 38 years at the Bethlehem Steel plant. I am presently the president of the Steelworkers Organization of Active Retirees, the acronym is SOAR. I understand that for some reason they discounted the South Buffalo Railroad and said -- oh, she's going to pass these out to you there, I hope. I don't have a lot of them. I didn't realize there were that many people here today, so if she will pass them to the Board members.

My father-in-law worked for the South Buffalo Railroad. He went there in 1936 and died of cancer in 19-- in the early '60's. And I'm wondering what happened here, why did they discount him? He died of liver cancer. Now the South Buffalo Railroad is a wholly-owned subsidiary of the Bethlehem

Steel Corporation. It is not a contractor (Inaudible). Their property was on the Bethlehem Steel Property at the Lackawanna plant. No other railroad could come into the Bethlehem Steel plant, the Lackawanna plant. They brought everything in and they had no cabooses.

Some people think conductors (Inaudible) have cabooses. Well, they don't have cabooses. They either rode the engine or they rode the car as they were bringing them in, and they brought all the steel up to the open (Inaudible) or the blast furnace, wherever it was coming -- going to, and that's what came in from the ra-- for the radiation with all the radiation on it. And so I'm not sure exactly why they discontinued that because there probably are other South Buffalo people that have been discontinued. And I know that there are other Bethlehem Steel workers that have just been -- not really discontinued, but we don't know too much about this.

I have filed -- oh, three or four years ago when this came out, and I never heard

anything from anybody about this at all. Nobody ever said Fred, you're rejected. And at that time I did mention my father-in-law's name, and nobody ever said he was rejected. Well, the last meeting that I was out at in (Inaudible) Park, that's where I found out that they had literally discon-- this said that the South Buffalo Railroad is not part of -- was a contractor. They -- I don't have all the information with me because it is -- I'm getting more and more and I'm sending it to Annette and Annette is getting it, and I've talked to the union district four office and they have many cases of a thing that show that they were negotiating with them for the Bethlehem Steel or the pensions and everything else. I have one copy of the book, but I think it's important that we get -- why did they just not -- or why did they say that the South Buffalo Railroad was not part of the industry there. Their Buffalo tank was there, South Buffa-- now these are subsidiary -- wholly-owned subsidiaries, and I don't know what happened to all them

books.

Apparently -- I was hoping to give them to you people and I have one copy of that so unfortunately that's what happened. They were supposed to go up to the front table there. We can make more if you want them. If you let me know that you would like them, I certainly will get them for you. There's interesting part -- this is from the Courier Express, 1967 edition, and they did quite a number on the South Buffalo Railroad. I think that picture on the front page -- I think that's a posed picture. You'll never see an engine that close to that much fire. That's kind of a no-no, but anyhow, they are the people that moved the steel in and out of the plant. No other railroad could do anything in the plant, that was it. So that is what I came to speak about and we'll see where it goes from there. Thank you very much.

**DR. ZIEMER:** Thank you very much, and I -- am I correct in assuming that the -- at least the Department of Labor has this information or are looking into that?

**UNIDENTIFIED:** (Off microphone) (Inaudible)

**MR. ELLIOTT:** You need to come to the mike, please.

**DR. ZIEMER:** Please use the mike.

**UNIDENTIFIED:** (Off microphone) (Inaudible)

**UNIDENTIFIED:** (Off microphone) Turn it on.

**MS. PRINDLE:** Annette Prindle, district director in the Cleveland district office. I have the information that Fred has submitted and I just got the last of it last week, so I will submit that to our national office.

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

**MS. PRINDLE:** Thank you.

**DR. ZIEMER:** So there'll be some follow-up that will occur, Fred. Thank you.

**MR. STOCKWELL:** Thank you very much.

## SPECIAL EXPOSURE COHORT RULE

**DR. ZIEMER:** The next item on our agenda is the presentation on the Special Exposure Cohort rule, and Ted Katz is going

to lead us through that. Ted?

**MR. KATZ:** Hello -- hello? Is this working? Thank you, Mr. Chairman, members of the Board. I was speaking with Genevieve before this session and she suggested I raise for y'all a possibility which is -- this presentation is discuss-- focused on discussing changes from the last notice of proposed rulemaking that you reviewed to the final rule. I know it's been a while, though, since you reviewed the notice of proposed rulemaking and the previous -- even though you spent a lot of time on this rule over the last couple of years, it's been a while since you've been looking at this material. So if you'd like, I can sort of give you a thumbnail sketch of the overall rule, the requirements and so on before I go into the issues of what we changed and why, if -- if there are a number of you that think that that would be useful. If you don't want me to spend the time, though, I'll just launch right into the change issues as I've prepared. It's up to --

**DR. ZIEMER:** Any objection to the

overview?

**MR. ESPINOSA:** I was just kind of wondering if you have maybe a red-lined copy?

**MR. KATZ:** No, I don't.

**DR. ZIEMER:** Why don't you proceed -- any objection to having the overview and --

**DR. MELIUS:** This will still leave time for questions?

**DR. ZIEMER:** Yes.

**MR. KATZ:** I can -- but Rich, I can certainly -- I'm not -- I don't think we'll have time in this session. I can certainly -- at another time I can go through the rule at that level, if you'd like. I mean if -- if the Board would like --

**DR. ZIEMER:** But you're going to point out the differences --

**MR. KATZ:** Yeah, I'm going to point out the major differences here, but I understand what Rich is saying, and if -- if you'd like a more detailed treatment, you know, that's something I'd -- we won't have time to do in this session.

Okay. So just one other thing to

mention, which is this slide presentation is slightly different from the version that's handed out, if all of you have that. I've fussed with it a little bit just to pull things together and add some things that I had left out.

So let me just then go about the basics of the rule and so on as it stands and the requirements for it. I'm going to add more to -- than what we have here, but EEOICPA has two basic requirements for HHS for us to add a class to the Special Exposure Cohort. One, we have to find -- this is a reminder, but we have to find that it's not feasible to estimate doses with sufficient accuracy and just -- in shorthand I talk about it's not feasible to do dose reconstructions in my presentations. And secondly, that there's a reasonable likelihood that the radiation dose is -- may have endangered the health of members of the class. So those are sort of substantive requirements in EEOICPA that we have to address to be able to add a class to the cohort.

In addition there are sort of three

important procedural requirements that we have to address, one being that to initiate the process of considering a class, we need a petition from that class. And the second being that the Board has an opportunity to provide advice on the addition or non-addition of a class in response to a petition. And thirdly, that once a decision is made, if a decision is made by the Secretary of Health and Human Services to add a class to the cohort that Congress has a 180-day period to consider that decision, to expedite it within that period, to reverse it, what have you. And these are all -- again, these are all requirements of EEOICPA, not things that NIOSH formulated.

So going from there then, you know, the NIOSH rule, just in an overview sense, does the following things. One, it -- it puts together procedures for implementing all the statutory requirements that I just described. It also establishes the requirements for who's an eligible petitioner and the contents of a petition. And I think the -- we've made the

requirements of an eligible petitioner exceptionally broad, I think. It's hard to think of how anyone is left out, according to those requirements. In terms of contents of the petition, we've made, you know, the bar exceptionally I think low in the sense that -- that really what petitioners are doing is simply having sufficient information to indicate there might be a concern about a class, it should be considered to be added to the cohort. It is not the burden of the petitioners to make the case that a class should be added. That's really the burden of the whole evaluation process. All they're doing is bringing to the attention of NIOSH, this Board and the Secretary of Health and Human Services classes that need that consideration. And then it provides procedural -- sort of procedural rights to the petitioners throughout the process.

Let me just then summarize the process as it is in the final rule very shortly, and then I'll get into what we've changed.

So the process begins -- the

petitioning process begins with getting a petition from a class, and that's from any parties -- the eligible parties or either members of the class, employees themselves or their survivors, or unions that represent or represented members of that class, or a representative that members of the class or their survivors empower to represent them and submit a petition on the behalf of the class. Those are the sort of three categories of petitioners.

They submit a petition. It comes to NIOSH, and the first thing NIOSH does is determine whether the petition meets the basic requirements -- again, the low bar I expressed -- for receiving full consideration of NIOSH, the Board and Secretary of Health and Human Services. That is a -- as it's laid out in the rule and in more detail in procedures that we've -- internal procedures that are available through our web site for how we're going to handle this. You know, that is a process that involves working with the petitioners -- NIOSH working with the petitioners and

helping them address those requirements.

And then NIOSH makes a proposed finding as to whether the petition ultimately then meets those requirements for being considered. If it does, it goes on to the next step. If it doesn't, the petitioners have an opportunity to request an administrative review of that decision, that find-- proposed finding. And that review would be run by the director of NIOSH and it would involve individuals independent of the OCAS process of making the determination in the first place.

Okay, so then on to the next step. So then NIOSH has decided now that a petition meets the requirements and deserves evaluation. The next step is for NIOSH to do its evaluation of the petition according to these two criteria -- address whether or not it's feasible; and if so, make determinations about health endangerment for that class. And just -- well, I'll get into details of that actually in doing the comparison, so I won't run through those now.

At the end of that process, NIOSH produces an evaluation report that goes to the Board and the Board will hold a session or sessions to address that petition. The Board will -- the petitioners will be invited to present -- this is part of their petitioning rights -- to present their views to the Board on the NIOSH evaluation which they'll receive, as well as on their petition. The Board will do its deliberation, considering all this information and other information it deems appropriate and will make a recommendation, its advice, to the Secretary as to what should become of the petition.

I need to step back a second. NIOSH -- in its evaluation, it could -- it could, as a result of one petition, advise that there be -- a class be added to the cohort, that there be a class not added to the cohort, or both. I mean 'cause there could be multiple decisions. We could have received a petition that in fact when you do the research, you find there may be some members, there may be some class for which

you can't do dose reconstructions and other members for which there's sufficient information to do dose reconstructions, so there could be multiple decisions.

The Board then gives its advice, and then the next step is to have a proposed HHS decision and the director of NIOSH would issue that proposed decision as to whether to add one or more classes, to not add classes, so on.

Then the petitioners have the opportunity to seek an administrative review if we decide not to add a class to the cohort, or if we make a determination about health endangerment that would, in effect, potentially exclude someone from being a member of the class in either of those cases. So any sort of adverse -- adverse result, they would have the opportunity to seek administrative review.

At the conclusion of that process, or if there is no request, you move straight to it, the Secretary makes a determination. If the Secretary decides to add classes as required by EEOICPA, that determination goes

into a report to Congress and Congress then has its 180 days to review that decision or act on it beforehand what it may do. And then at the end of that whole process, NIOSH will report out the results.

And there's actually reporting throughout the process to the petitioners and to the Board on the steps along the way. So that's just a short of nutshell of the rule.

Now let me -- unless there are any questions about the general, let me get into what has -- what we've changed from the second notice of proposed rulemaking that you reviewed a year ago -- spring.

Okay, so in the second notice of proposed rulemaking our feasibility test was that if we had sufficient -- access to sufficient information to estimate the maximum radiation doses that could have been incurred in plausible circumstances by any member of the class. That was the basic test for feasibility. In addition, we had provisions -- in some circumstances feasibility could be cancer site-specific

and hence cancer-specific. We had provisions so that we could determine that it's not feasible to do dose reconstructions only for individuals with certain cancers and to hence add a class to the cohort that would be cancer-specific, limited to certain cancers.

So the Board's advice in response to that proposal was to admit these provisions that would allow HHS to add a class limited to certain cancers -- the cancer-specific classes, as they've been referred to -- and also to develop guidelines on how NIOSH would determine feasibility, implementation guidelines.

The public's comments on feasibility -- well, I mean, the popularity contest was won on this issue of omitting cancer-specific provisions. We -- we heard this from almost all commenters, and a lot of commenters felt that this was -- this is really sort of -- would be too much of an inequity that -- that classes that we add would be cancer-specific when the classes that were established by Congress aren't limited to

particular cancers except for that they're limited to the 22 cancers that Congress specified under EEOICPA.

They also recommended in public comments -- for example, a time limit on dose reconstructions as a feasibility test, a cost limit on dose reconstructions, deficiency or absence of records as a test, and they also -- public commenters asked for additional details in the rule or in guidelines regarding feasibility.

The final rule on feasibility -- the changes from the second notice of proposed rulemaking, we accepted the comment to eliminate the cancer-specific provisions. They're gone and the rule is very clear that there is no cancer specificity in these determinations.

We also made a lot of clarifications. Clarification about the -- clarify the feasibility determination for petitioner-claimants for whom NIOSH cannot complete a dose reconstruction. This is -- again, if NIOSH has attempted to do a dose reconstruction for someone and cannot

complete it, the idea from the inception was that that would be a sufficient basis to determine it's not feasible to do dose reconstructions for a class involving that individual -- involving that individual -- you know, the circumstances of that individual. And there was some misunderstanding, though, particularly in public comments, about whether that really applied, so we made it very explicit in the rule that there's no further determination required with respect to feasibility.

We also clarified the limited role of maximum dose determinations and the process information -- and clarified that process information may be necessary. What that's about is the rule, as it was written before, would have had us determining whether we could estimate maximum doses in every case. However, we certainly expect we'll get petitions in cases where we actually have loads of data, and we're not talking about doing maximum dose estimates but we're doing very specific, very precise dose reconstructions, relatively speaking. And

in those cases, you know, there'd be no point in proving that you can do maximum doses. The point is to prove that you can do dose reconstructions, so...

We also clarified that NIOSH must have some information from the site where the employees worked, and this relates to a statutory provision relating to probability of causation determinations that sort of -- in a -- in a sort of deductive sense requires that you have some information from the site to do a dose reconstruction.

Now as I said, we have internal procedures, as well, to flesh out how we will actually go about the dose reconstruction process. There are step-by-step procedures that our folks inside will use to do these -- I mean -- I'm sorry, to do these evaluations of petitions, and as I explained, it's a very abbreviated process in a case where we've done -- attempted a dose reconstruction and couldn't do it. But for all other petitions -- I mean the place we will start, because we're trying to be very efficient in how we handle these

petitions, considering that we may get many petitions and they're likely to require a lot of work in any event. But we'll first go to our dose reconstructions that are complete or ongoing to see if we have the evidence there to address the feasibility issues that are raised by the petition.

And then the next step is if those existing dose reconstructions, if there are any, are not determinative on the issues, then we go according to the hierarchical approach that you use also for dose reconstructions, which gives preference to personal dosimetry information. And then the second order of information would be area monitoring and the third order would be source term process information. So we'll follow that same hierarchy in evaluating feasibility.

Oh, we have also a number of provisions -- other provisions for timely consideration of petition. One -- and this is also in the rule, as well as the procedures -- the OCAS director may determine that records/information is not or will not be

available on a timely basis. So even if the -- if records exist, if they can't be accessed in a timely basis, the director of OCAS could make a determination, and in effect you would treat it as if the records didn't exist.

Second, we're -- the evaluations that NIOSH does will be limited to address the feasibility issues identified by the petition and those required to demonstrate feasibility. And what we're trying to say here is this -- this is not going to be -- can't be, for us to efficiently deal with petitions, a fishing expedition in terms of evaluating the petition. So the issues -- the feasibility issues that the petitioners raise will be addressed, but you know, just to give you an example, you know, if you have a petition covering an enormous time span, an enormous number of operations and so on, and the petition issues are specific and limited, we wouldn't be fishing for other issues there may be to feasibility that one wouldn't know, haven't been raised as suspect, and so on on our own.

And the third is the petitioner issues that are not critical for determining feasibility may be addressed separately if they would substantially delay consideration of the petition. This is just to say that if -- if we can make determinations about feasibility but the petitioner raises some issues that don't impair our ability to do dose reconstruction but they are issues about, for example, the quality of monitoring or what have you, we will address those issues but, you know, we'll bifurcate that so the petition process can move on if -- if it would require a lot of time, if it's going to require months to address those issues and they're not determinative.

So the second test -- again, if feasibility's the first, second is health endangerment. In the second NPRM we limited determination to an employment duration requirement for exposed employees. We used the same 250-day requirement that applies presently for the employees of the gaseous diffusion plants -- that's our default. But we also allowed for HHS to specify presence

as sufficient in cases -- discrete incidents of exposure in which doses were likely to have been exceptionally high.

The Board -- you -- advised us on health endangerment -- you recommended that employees be credited for days of employment within separate classes if necessary to meet the 250 work days criterion. In other words, if an employee worked 150 days in one class that's in the cohort and 100 days in another class, combine those days and that would still meet the health endangerment requirement.

And the public comments on health endangerment, there weren't that many. One was to allow -- again, just as the Board recommended -- employees aggregate the days of employment within separate classes. And a second comment was to waive the 250-day requirement for operations that lasted fewer than 250 days. So this is what we did.

We added a provision, as you recommended, to allow employees to qualify as a member of the class by aggregating employment among classes included in the

cohort. This includes classes that we add, as well as the classes that exist already -- or the class that exists already -- classes.

And we covered that second issue that I just raised. Operations that last fewer than 250 days would be covered by this same provision. It would give in effect equal treatment to all employees, so if someone is in a short-term operation, that class can still meet the requirements to be added to the cohort, and that employee had worked at another -- at another SEC site, that employee would -- would qualify. It puts everyone on the same level here.

**DR. ZIEMER:** But not by itself.

**MR. KATZ:** Not by itself, no. Not within -- they have to have worked 250 days, unless we find that there's exceptionally high exposure and simply presence would be sufficient, in which case it wouldn't matter what duration the operation was. It would have no effect on them. They would be covered.

Other Board comments and HHS responses, the Board recommended we include a facility

definition in the rule. However, EEOICPA, as the Board discussed -- EEOICPA already specifies facility definitions -- two different definitions, one for AWE facilities and one for DOE facilities. And we're -- though we're required to live by those definitions, we did add a footnote to the rule to explain this was a Board concern that multiple buildings on a site could be considered a single facility, but that -- but will be a case-by-case determination as to whether, you know, a petition is coming from a facility or not, based on those EEOICPA definitions.

The Board also made recommendations about the petitioners' evidence regarding unrecorded exposure incidents. And you made really two recommendations. One, the rule -- the proposed rule could have been interpreted to require three affidavits when you're down to a situation where you're relying on witness evidence that an incident occurred, and the Board recommended that it be two. And the other Board recommendation was that where there are no surviving -- or

can be found -- eyewitnesses, that you be able to consider the evidence from non-eyewitnesses, and we have changed the rule accordingly. We have actually eliminated -- there is no numerical requirement whatsoever for the number of affidavits, and we are allowing for people who have second-hand information to provide evidence.

The Board also recommended that there be an administrative review of findings by NIOSH that a petition doesn't qualify for consideration -- that front end of the process that I explained -- and we have included the review process as I just described it, run by the director of NIOSH.

Okay, other changes/clarifications in the final rule. We have -- and some of these arise from actually figuring out, sort of working through in the step-by-step process we had to to develop the implementation, internal procedures, what were going to be some implementation problems, and some of these relate to that.

The first one on here is the number of petitioners per petition. We didn't have

any cap on the number of petitioners. We didn't have any verbiage on the number of petitioners in the proposed rule. We have capped the number of petitioners per petition to three. It doesn't -- it doesn't limit the number of people covered by the class, but -- but it became apparent to us that it would be really unmanageable and -- and detrimental rather than helpful for the petitioners to have a large number of petitions. You know people, when they think of petitions, of course they think they get strength by numbers. In this case, our determinations are technical, not based on the number of petitioners signing. But the problem is if you have large number of petitioners signing, they gain all the rights of the petitioner -- rights, for example, to present to the Board. If you had 100 petitioners that you had to hear from before the Board could even begin deliberations, that might be an issue. But there are all sorts of -- I mean NIOSH has to first, on the front end, determine that the petitioners are all qualified

petitioners, as well. It's an administrative process, but the more petitioners, the more work that would be. And the process, you know, runs through all the way to the time of appeals.

And if you have differences, you know, between petitioners on issues -- on the front end, for example, of getting the petition in shape to meet requirements, if you have differences between them, the more petitioners there are, the harder it's going to be to get that petition past the starting block. You know, on the back end, on the appeals decision, if you have differences between petitioners you can have issues there, too.

We also added a new information requirement. This is similarly related to sort of practical problems in implementation. Once we've considered a petition, if someone submits a petition after that, if they submit petitions -- let me back up -- conterminously. If we receive a bunch of petitions relating to the same class, on the front end we have provisions

to aggregate those, to combine them and treat them as -- in effect -- if they were one petition. You know, they'll do the process together. But if we've already done the work of evaluating a petition, you know, at that point forward, or if the Secretary's already decided on a petition, you get another petition in that's precisely the same as the petition that was already considered, there we have a requirement then that that petition, the new petition has to provide new information that hasn't been considered, to be considered. Otherwise, we'd end up in -- we could end up in an endless loop where we'd have to go through the whole process, despite the fact that we've already deliberated. It would still have to come before the Board. It would still have to go to the Secretary. This was a way to avoid that, which would get in the way of us dealing with other petitions that haven't been considered.

Evidence requirements, we clarified that the evidence provided will be weighed, in effect, for adequacy and credibility. I

mean that -- that should go without saying, but needs to be said and we added that clarification to the rule.

We added a review -- we didn't add, we elaborated exactly how the review of proposed decisions would occur, and that is, again, to remind you, once NIOSH makes a recommendation on behalf of HHS, a proposed decision or decisions to add classes, not add classes, then we laid out elaborately what the process would be by which a petitioner would seek a review if it's a denial of a class or it's a health endangerment determination that might exclude individuals, and that process is run by HHS. They're independent -- a panel of independent -- three independent people from HHS personnel would -- would do that administrative review and that would be considered by the Secretary. And there are more details in the rule about how that's done.

Finally, multiple -- multiple decisions. We also clarified -- as I said on the front end, when NIOSH evaluates a

petition, it may find that there are actually a number of decisions that come out of the same petition, decisions to add or not to add both. And it wasn't -- the rule didn't clearly allow the Secretary to issue multiple decisions, which would have been held hostage, you know -- the decisions to add a class would be held hostage to decisions to deny one because people would want a review and so on, so we have clarified that.

And we also clarified protection under the Privacy Act, that -- that the Board is going to be involved in a process of evaluating these petitions and NIOSH and the Board are going to have to work together carefully to ensure that privacy is maintained, very similarly to the issues you'll have in reviewing dose reconstructions, but to protect the privacy of individuals when we're dealing with a class. And not all members of the class are necessarily willingly sort of giving their data to the public.

And that's the end of my prepared

remarks, but...

**DR. ZIEMER:** Okay. Well, we'll open the floor for questions then, Ted. Thank you very much. Who's first? Okay, Jim.

**DR. MELIUS:** I'll go. What -- just review for me the length of time from -- roughly from the time a petition arrives at NIOSH to the time people would get compensated.

**MR. KATZ:** Well, I mean -- I mean it depends, of course, but -- but starting from the back end and going forward, just 'cause it's easier, I mean there's 180 days that Congress has the opportunity to review a decision before it becomes effective.

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

**MR. KATZ:** So that's a given, 180 days, you know, unless Congress acts before then. Then you have -- let me just -- well, I'll just keep going from the back forward. Then you have the Secretary's determination, you know. I don't know what the length of that is, but in part there is -- if there is going to be an administrative review, the petitioner has 30 days to request such a

review, and then there's whatever time that review requires. You know, then moving forward from there, there is the -- NIOSH making the proposed determination, after the Board has given advice.

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

**MR. KATZ:** You know, there's the Board's deliberations. I think it's going to be pretty variable how long the Board requires to deliberate over a petition because these are going to be different scope petitions and so on. I think some, you know, are likely to be much easier than others, simpler and quicker.

**DR. ZIEMER:** Excuse me, Ted. Does the NIOSH determination -- is that specified in --

**MR. KATZ:** In the rule, so it's --

**DR. ZIEMER:** -- the rules by how -- I mean in -- the number of days?

**MR. KATZ:** No, there's -- there's no time requirement on it 'cause it'll depend -- it'll be a case-by-case, but -- and then backing up from there, there's the NIOSH evaluation of the petition. You know,

again, in some cases -- for example, the case where we've done a dose reconstruction and couldn't do it -- attempted a dose reconstruction and couldn't do it, that, you know, NIOSH evaluation is going to be pretty quick. In a case where it's a very narrow class, I think, and -- and there's very clear information, it's going to be much quicker. If it's an enormous class covering all sorts of operations over a long time period, you know -- I mean I think you would expect that evaluation would take a good bit of time. And it depends also on how many allegations -- you know, issues are raised by the petition itself, too.

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

**MR. KATZ:** So how much is documented there and how helpful that is to the petition process.

**DR. MELIUS:** 'Cause I saw at least one *Federal Register* notice in there for --

**MR. KATZ:** Oh --

**DR. MELIUS:** -- for -- before the Board considers the -- so there's --

**MR. KATZ:** -- there's multiple *Federal*

*Register* notices.

**DR. MELIUS:** Right, yeah, I -- okay.

**MR. KATZ:** Those -- I mean we really don't think that that's -- those will really affect timing. I mean those will be worked on concurrently with doing NIOSH evaluations, with the Board doing its action and so on, and since those are just notices versus regulatory actions, which you're familiar with, you know, they should be, you know, relatively expedient.

**DR. MELIUS:** Yeah, I think they're less than four years or whatever.

**MR. KATZ:** Less than four years.

**DR. MELIUS:** Do that. But there's also provision in there that the Board can collect its own information, also?

**MR. KATZ:** There is. I mean the Board has the right to determine -- it has two -- I mean it actually -- it can re-- you can request of NIOSH to go back and do more evaluation, after NIOSH produces a report, you know, but there's this open-ended catch-all for...

**DR. MELIUS:** So -- so what's a fair

assessment of the -- the process in a...

**MR. KATZ:** The time?

**DR. MELIUS:** The time, yeah.

**MR. KATZ:** Well, I -- again, I think it's going to be all over the place. I think they're going to -- there will likely --

**DR. ZIEMER:** But you can --

**MR. KATZ:** -- be some cases that --

**DR. ZIEMER:** -- readily figure out a minimum pretty fast, and the minimum -- you're going to have to allow the Secretary of Health and Human Services 30 days plus the evaluation time, so call it 30 plus 30, minimum. We're going to probably have about a 30-day turnaround time, minimum. NIOSH will have another 30 day minimum. Right away you're up to ten months.

**DR. MELIUS:** Yeah.

**DR. ZIEMER:** If everything is smooth and straightforward. So it seems to me one could easily say roughly a year from the front end to the back.

**MR. KATZ:** I think the exception might be -- might be -- those cases where we've

already found we couldn't do a dose reconstruction. But otherwise, yes, I think -- you know, at -- at minimum --

**DR. ZIEMER:** Even there, but you have the six months to start out with for Congress to look at it.

**DR. MELIUS:** You have the class definition issue that --

**MR. KATZ:** You do have the class definition issue.

**DR. MELIUS:** -- you know, which I think, you know --

**MR. KATZ:** Yes.

**DR. MELIUS:** -- is going to take as much time as -- I'm not sure that's very different from doing -- you know, a de novo petition coming in.

**MR. KATZ:** I mean I guess that -- we'll leave that to be seen --

**DR. MELIUS:** Yeah.

**MR. KATZ:** -- but --

**DR. MELIUS:** Yeah. What is it in this rule that took so long? What was the stumbling point? I don't --

**MR. KATZ:** I'm really slow.

**DR. MELIUS:** Well, we noticed that.

**MR. KATZ:** There is -- actually I worked really hard on this rule.

**DR. MELIUS:** No, and I'm sort of asking what --

**MR. KATZ:** There's -- HHS is a very big department with -- and there are a lot of people involved, and every person has to come up to speed. And then there, you know, three other departments involved. And -- and this rule is -- is -- you know, is -- in a way, it's very complex, even though it seems like it would be simple. But it's not. I mean the dose reconstruction rule, I would say, in a -- is really a much -- was a much simpler job than this --

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

**MR. KATZ:** -- because it's dealing with a situation that, you know -- you know, people don't -- we don't deal with it. There's no path, nobody's done this before, so --

**DR. MELIUS:** And so people should be happy that it took another year to...

**MR. KATZ:** They should be ecstatic --

**DR. MELIUS:** Because the --

**MR. KATZ:** -- yes.

**DR. MELIUS:** Okay.

**MR. KATZ:** Because it should have taken five. No, I'm not -- we -- no, we were -- we pushed very hard, and I think all the people involved pushed very hard to make this rule happen as soon as it could. But it was a difficult job.

**DR. MELIUS:** What about these guidelines on feasibility and so forth that you refer to in the rule? Are those available yet?

**MR. KATZ:** Yes, they're -- absolutely, they're -- I believe they're on our -- the OCAS web site and we should be providing them directly to all the members of the Board --

**DR. MELIUS:** Have you?

**MR. KATZ:** -- but I don't know that we have provided them to members of the Board yet, but --

**DR. MELIUS:** (Inaudible) not to the Board.

**MR. KATZ:** -- but they just hit the web

site on Friday with the rule.

**DR. MELIUS:** The petitions and everything.

**MR. KATZ:** Right, as well as the petition forms are on the web site, as well as the instructions, which will be very useful whether you use the forms or not, and so on -- which provide more sort of advice to petitioners on how to go about dealing with the questions.

**DR. NETON:** I'm getting some feedback that the guidelines -- I'm getting some feedback that the guidelines may not be on our web site just yet. I know the petitions are out there --

**MR. KATZ:** Is that --

**DR. NETON:** We'll make sure they get there --

**DR. ZIEMER:** Is Chris here? Does Chris know?

**DR. NETON:** Chris, do you?

**MS. ELLISON:** I'm sorry?

**DR. ZIEMER:** Do you know if the guidelines are on the web site yet, Chris?

**MS. ELLISON:** To my knowledge, the rule

is out there. There is information -- the forms are out there on the web site. I don't know anything about any guidelines. I do not recall --

**DR. NETON:** The guidelines --

**MS. ELLISON:** -- receiving any guidelines.

**DR. NETON:** -- will be out there as soon as possible, they're just not up there yet. The rule was just issued on Friday, so --

**MS. ELLISON:** Right.

**MR. KATZ:** The guidelines are completed and...

**DR. MELIUS:** What's in them, then? Can someone explain to us what's in them?

**MR. KATZ:** So that -- the guidelines are -- I mean I -- yes, I can. I mean it -- again, it's -- I just touched on it a little bit, but they're a step-by-step -- you know, to me they're kind of boring reading, but they're a step-by-step how we go about dealing with the entire process, from determining that they're qualified petitioners to helping the petitioners with

their submittal and meeting the requirements of a petition to -- I'm sorry, there's someone --

**UNIDENTIFIED:** (Off microphone) (Inaudible) copy of a petition if anybody wants to see it right now, the form?

**MR. KATZ:** Yeah, that's the pet--

**DR. ZIEMER:** That's the petition --

**MR. KATZ:** But that's the petition.

**DR. ZIEMER:** -- and not the guidelines.

**MR. KATZ:** Right, right, but these are -- we're talking about the internal procedures for how we deal with the petitions. They go through step-by-step the entire process of NIOSH preparing the evalu- - doing the evaluation --

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

**MR. KATZ:** -- and how it would go about addressing feasibility and health endangerment and so on.

**DR. ZIEMER:** Well, could we simply ask that, as soon as those are on, to --

**MR. KATZ:** We can provide these to the Board --

**DR. ZIEMER:** -- just give us either a

copy or just send us an e-mail and say they're ready and we can download them or --

**MR. PRESLEY:** Send -- no, send them, please.

**DR. ZIEMER:** -- or send them.

**MR. KATZ:** Yeah -- no, I'm sorry, I just -- I just -- I just assumed they were out, but I'm -- I apologize.

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

**DR. ZIEMER:** Roy DeHart.

**DR. DEHART:** Two inter-related questions. I realize you've been pretty well consumed with getting this all taken care of, but have you or others considered what the impact is going to be in the near term over the next six months or so, any feel for how many petitions you're going to have, any concept of what the workloads are going to be?

**MR. KATZ:** No, I mean -- in reality, no. I mean I -- in reality we don't know how many petitions we'll receive and what scope they'll be. I mean we do have some information. We have a variety of people who have already notified us of their intent

to petition. And if Larry were here, he could probably rattle off, you know, what the numbers were, at least.

**DR. NETON:** I can speak to that briefly. I think we've received somewhere on the order of three petitions -- potential petitions early on. We're in the process of drafting letters to notify those people that the SEC rule has been published and to evaluate whether or not the petitions that we received were valid under the construct of the regulation.

Other than that, we've been working very closely with Oak Ridge Associated Universities to develop the infrastructure and the computer resources to handle the petitions. That's in place on a fairly rudimentary basis. And we've actually gone through and done some mock petition evaluations to try to flesh out the details as best we could. That's about the extent of what we've done.

**DR. DEHART:** That was basically my other question, and that is -- I -- is there an issue of staffing? Do you have -- are

you going to have adequate staff? Is this going to be something that's going to have to be addressed by the Board or any recommendations coming from us?

**DR. NETON:** We hope we have adequate staffing. But as Ted indicated, we just can't predict the volume of the petitions coming in. Right now I believe Oak Ridge Associated Universities has identified three health physicists that will be doing the petition evaluations. A lot of the initial effort's going to go into the qualification phase to determine if, you know, more information is needed to become a valid petition, so we're working up that end, but until -- until we start receiving them, we really just can't predict.

**DR. DEHART:** I think my concern would be that of the same concern that the Board might have, and that is that -- are we going to see a bleeding-off of manpower from the thrust that we have ongoing in doing reconstruction, et cetera, and consequently slow that down in order to start addressing the -- the petition drive.

**DR. NETON:** We share that concern, and again, until -- until we see what's coming, we can't really, you know, staff to -- to handle the petitions until we know what -- what the level is going to be. I think -- I personally believe that what we have right now is adequate. I don't expect thousands of petitions. I mean given that we have 16,000 cases, if every 16 people apply for SEC status, you'd have 1,000 petitions. I don't think that's going to be the case. We're hoping that, you know, the valid petitions, the ones that are qualified, stay in the fairly low numbers, but it's anybody's guess.

**DR. ZIEMER:** Gen Roessler.

**DR. ROESSLER:** Ted, you mentioned that NIOSH has identified a number of situations in which they cannot do dose reconstructions?

**MR. KATZ:** No, no, I -- I said that --

**DR. ROESSLER:** That wasn't what you said?

**MR. KATZ:** -- when we do identify -- when we attempt a dose reconstruction and

can't complete it, that meets the requirement with respect to evaluating feasibility.

**DR. ROESSLER:** Okay. Then my question would be have there been any where you've identified that you can't do dose reconstruction?

**MR. KATZ:** Well, I mean the issue is -- right now is, the way we've organized our efforts to deal with dose reconstruction so far, almost avoids that because we're -- been dealing with the dose reconstructions we could do, as -- as Jim mentioned earlier, for example, the cases where there wasn't monitoring, we're not even -- you know, the profiles, for example, are not addressing the non-monitoring issue at this point, so I mean we've been doing dose reconstructions that are sort of the low-hanging fruit, the ones that can be the most expeditiously addressed at this point.

**DR. ROESSLER:** Okay, so that's not an area where you could predict what might come up. Then my next question would be what factors -- and maybe this is something that

comes up in the future. What factors would go into determining that you can't do dose reconstruction? I can see no monitoring. I guess I'm just trying to -- this is naive, but I'm trying to figure out where a situation where you'd say they qualify, which means they must have some sort of source term, and yet you can't do dose reconstruction. I guess this is addressed probably to Jim to kind of get a feeling for the -- you know, the impact of this on -- on all of us.

**DR. NETON:** Yeah, it's -- it's a difficult process. Without, you know, going through a detailed example of a real life condition, which we probably -- I'm not prepared to do here -- it's hard to envision. If -- if there were -- you know, there has to be two conditions, one of which is we can't -- we know there was radioactive materials present -- material were handled, but we really don't have a feel for the quantity, the upper limit of the amount of material that was processed, but we do believe that it -- you know, it was a very

large amount that we just can't put a cap on. Given that there are no cancer-specific exposure scenarios now, though, one could envision certain cancers -- particularly lung cancer, maybe -- not being able to put an upper cap on some exposure scenarios for a lung cancer. That would of course bring in all 22 cancers, so that -- I think that's a requirement -- right, Ted? -- that if one -- one cancer -- one particular cancer cannot be quantified, dose reconstruction can't be done, then all of the rest are in. And so, you know, you'd have to look at organs where there's a large potential for dose. And clearly for inhalation exposures, that would be the lung cancer-type scenarios. But it's hard to --

**MR. KATZ:** Well, it's -- it's circumstances -- I mean in general it's circumstances where there -- where you don't have source term and process information, which, you know, is -- is not unheard of.

**DR. NETON:** And I could say that we're looking through this right now. Some of this is work that we've done -- we've done

so far with ORAU. We've actually been looking through, you know, where these situations might exist. But it's too early for us to comment on anything that we've done so far.

**DR. ZIEMER:** Jim.

**DR. MELIUS:** Yeah. I think Gen's question's very good because I think the chief problem with what you've done -- and maybe we haven't seen everything -- is that you've never -- you have yet to define sufficient accuracy, and so you're doing that on a case-by-case basis, which then's going to throw it back on the Board to try to make some determinations as to the quality of your dose reconstructions through our contractor's review. And secondly, the -- the quality or the qualifications of the Special Exposure Cohort petitions, you know, based on some set of arbitrary guidelines -- I -- since we don't have them in front of us and you're not presenting them today, it's hard to talk about them, but it seems the burden's on us. Now we had requested in our comments that we have an opportunity to

review those guidelines, and I'm a little confused as to where that stands. My understanding from -- this draft was -- or this final rule was that we were not going to be given that opportunity, or at best we were going to be given it in parallel to the petitioning process. But it also would seem to me that people applying for petitions would have to know something about those guidelines 'cause those are what are going to determine whether they qualify or not.

**MR. KATZ:** Well, I mean actually they don't. Let me just address a couple of those thing-- both of those issues you raise. Start with the petitions. The petitioners don't need to know that, because what they need to know is simply that low benchmark that gets the petition -- what is required for a petition to receive a full evaluation, and that is the only information that -- they're not required to prove the case that -- of feasibility whatsoever. And they're given full and complete and clear information about what the requirements are for submitting a petition that's valid and

gets evaluation. So there's no -- this -- it doesn't raise any problems for the petitioner.

I'd also say that I think, despite the fact that it's qualitative, it'll be -- it'll be very clear. It's not -- there -- I don't think there is a problem with the Board making determinations -- different determinations about when it's feasible because in every case it's -- if you can't put -- if you can't estimate maximum doses in the worst case, that's when you determine that it's not feasible. And those situations, despite the fact that it's murky as to how much source term information do you need to be able to do that and proc-- information you need to do that, I mean it'll be very clear that you can't --

**DR. MELIUS:** Well --

**MR. KATZ:** -- you can't estimate --

**DR. MELIUS:** -- yeah, but then the corollary -- the corollary of that, as I pointed out many times, is that that means that you're being -- that there's -- it -- going to be an error in terms of doing your

dose reconstructions then. Either your actual dose reconstructions aren't going -- being done with sufficient accuracy, which we would pick up in the re-- you know, the review process and have to make some judgment on because you're basing them on maximum dose and does the maximum dose really provide a sufficiently accurate dose reconstruction I think is the question. And if your guidelines don't address that -- and I can't tell now, you've got me even more confused -- then I think we're going to end -- the Board is going to end up having to make that assessment 'cause we're reviewing both the petitions and your -- and your program. It's either one or the other is going to be faulty 'cause there's a direct trade-off between -- between the two.

**MR. KATZ:** If we've completed a dose -- if you're reviewing dose reconstructions and we've completed a dose reconstruction -- I mean you can have issues about the dose reconstruction. If it happens to be a dose reconstruction which is in effect -- or prac-- you know, a maximum dose or

thereabouts because it's relying entirely on source term and process information -- I mean then -- you know, you will very clearly have laid out for you the assumptions, the scientific basis for making that maximum estimate, and whatever is questionable about that you will have the opportunity to scrutinize. So I mean actually in reality, in practice, it's not going to be sort of a mystery as to what to do or what to recommend in those cases. But you know, we'll see.

**DR. MELIUS:** That's correct, and I think the Board's going to have to see it on a case-by-case basis. And rather than having a set of guidelines and regulations to follow, we're going to have to be determining it as -- as we go along and I think there's a lot of potential problems there and I think a lot of potential unfairness to the -- the claimants. And I think you're also wrong about -- I mean I don't think claimants are going to want to submit petitions without an understanding of whether they qualify. I mean who wants to

spend the time and effort and wait around for at least a year to get an answer back when chances are that, you know, you may or may not qualify 'cause you don't understand the criterion. Simply because the initial criteria for qualifying as a petitioner are low does not mean that, you know, the probability of the chances of success for your petition are -- are going to be high or...

**MR. KATZ:** But the rule very clearly, though, specifies the likely circumstances in which feasibility becomes an issue. I mean where there isn't source term information, where there isn't process information, it pretty clearly expresses those -- those -- those basic general guidelines. So the petitioners have those in the rule and they will -- there -- there isn't more -- you can't turn the petitioners into health physicists to take them further and know their, you know, probability of success. But it's -- you know, we've limited the burden of what it takes to submit a petition -- I think -- low enough

that we're not taxing the petitioners with an inordinate amount of work to submit a petition. And from there, you know, the petition process -- you know, the burden is on NIOSH and you and the Secretary -- you, the Board.

**DR. MELIUS:** Exactly, that's the problem.

**DR. ZIEMER:** It sounds like the guidelines that they're talking about here are more in the way of operational procedures on stepping through the right steps, more like a checklist. The -- you -- your point, Jim, that we may indeed end up looking at these on a very individual basis, almost like individual dose reconstructions, is probably true. I think we were hoping that there would be some -- little more easy way just to say if you meet these criteria, it's pretty straightforward. But it sounds like that's not going to be the case, that the guidelines are not -- I don't think they were what we were thinking about at the time.

**MR. KATZ:** Well, there is --

**DR. ZIEMER:** At least it appears that way to me. We need to see them, I suspect.

**MR. KATZ:** I mean there have -- let me just -- the guidelines do, for example, reference the parts of the dose reconstruction guidelines addressing technical issues of how you do dose reconstructions, when you are limited to source term and process information and so on. But I have to say that the Health Physics Society, which represents all the professionals -- health physicists in this country and -- and all public commenters and the Board, they're -- and our entire staff have not been able to come up with litmus test type approaches, little sort of simple tests that would work. And if we could have done something like that, that would mean just checking a box, we would have loved that. I mean that -- that's wonderful. But -- but this, I don't think, is a situation that gives itself to that. It's going to take judgment.

**DR. ZIEMER:** Tony.

**DR. ANDRADE:** I'd just like to state

that -- I'll address three items here. Number one, in the rule it is stated that NIOSH/OCAS will provide a report to the Board for its consideration. So by default, we will see every single one of them. That's part of our jobs.

Number two is that with the detailed procedures going on the web, and if people feel like it will do them -- if it will provide them some advantage, then by all means go and read them and -- and seek advice and -- and use them if -- if you will and -- in the petition process, although I doubt seriously if those detailed, step-by-step procedures for review are going to help -- personal opinion.

And third is let's not mix apples with oranges. If a report comes down to this body and says that NIOSH has looked at these -- has looked at an individual petition and they believe that it may qualify -- and by the way, they let the petitioners know what's going on -- then that has no bearing whatsoever on the quality of dose reconstructions that have been done in the

past. In other words, that does not bring into question the whole issue of sufficient accuracy. That means that they have identified -- not the types of cases that they're working on now, but the more complicated cases that are going to come up in the future. That will bring around complicated questions that perhaps they and we will determine insofar as the issues of feasibility are concerned. So I -- I just want to make that clarification. There is no connection between sufficient accuracy and ruling on an issue with respect to Special Exposure Cohort status.

**DR. ZIEMER:** Other comments? Yes, Leon.

**MR. OWENS:** Ted, have any plans been made to provide educational assistance to claimants from the standpoint of going to the different sites where we have met and having workshops for claimants or other interested individuals who might want to submit a petition?

**MR. KATZ:** As far as I know, we don't have any plans for that.

**MR. OWENS:** And I guess a follow-up question then -- I think that the Board, when we look at all the sites that are listed per EEOICPA, I think there could be a great concern from the standpoint of resources. And I don't know exactly when that question would surface for NIOSH, but if we look throughout the country at -- and if we take a look at the definitions, whether it's a facility or a site, of all the possibilities that we could encounter, I think it lends itself to resources for NIOSH. And of course that's a -- my own opinion, but I guess the question is, at what point in time would the Board be informed of the need for additional resources?

**MR. KATZ:** I think you -- we -- we would recognize it and act on it as quickly as we could, and without even requiring the Board to -- to ask us to address a resource problem like that, but I mean we of course -- I think as we come in -- you know, we have Board meetings very frequently and if we're in a situation where we're deluged with

petitions, you'll know it, as well, because we'll be posting information about petitions and so on and we'll be informing the Board as this goes along as to how we're doing.

**MR. OWENS:** I understand the point that you made from the standpoint of not knowing exactly how many petitions you might receive, but I was just interested as to whether or not any projections have been made, because again, we're looking at over 300 possible sites. And I think there are a lot of people who are very upset and I think a lot of people also are interested in SEC status. So I can then surmise that there might be a tremendous number of groups of individuals who might petition.

**MR. KATZ:** I think that's entirely possible.

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

**MR. GRIFFON:** I tend to remember a phrase, "feasible to estimate with sufficient accuracy", so I think sufficient accuracy is a part of this equation. I just wanted to build on something that Jim was saying. The feasibility test seems to be

laid out in this with this maximum dose, but the sufficient accuracy I don't think is laid out at all. And you know, I saw some of the examples that were in the text. You know, I can come up with an example on my own where you say well, I know something about the source term, I know very little about the -- how much this class, these individuals accessed near the source term, what the particle size was, what the solu-- you know, there's a lot of unknowns, but I do know a little about the source term, so I can come up with a maximum -- you know, let's say 4,000 rem to some organ. But when I -- you know, there's no condition in this that says well -- so I -- so I got to maximum this, I get some sort of maximum dose, but there's no condition on this that says anything about how you're going to use that in the individual dose re-- so it's feasible that I can do a dose reconstruction there at that point. Then for the -- all those people in that class, theoretically you would go back and do your normal dose reconstruction process. But there's no

condition that says that you use -- so you've got all -- maybe all you have is one datapoint, so you're going to say that the dose is somewhere from zero to 4,000. Where's your -- where's your median, you know? There's no condition in the Special Exposure Cohort that requires you to know anything more other than zero to 4,000. You have -- you know a maximum, that's good enough, they don't qualify for Special Exposure Cohort, they're back in the dose reconstruction process, and then you can say well, you know, yeah, we know 4,000's the max, but it's very unlikely that the individual spent much time there. For all these scenarios we believe that it's more toward the zero so we'll skew our distribution with a median toward 20 rem, with a tail going out to 4,000. It's a little different than the example presented in the text, but I think --

**DR. NETON:** Well, they're -- if I can just address that --

**MR. GRIFFON:** Go ahead.

**DR. NETON:** -- briefly. There is no

requirement that would put a distribution about the exposures, first of all. If it were so insufficiently known --

**MR. GRIFFON:** But there's no requirement to put a maximum dose, either, is what I'm saying.

**DR. NETON:** Well, you couldn't. That's what I'm saying. So if we knew what the maximum potential could have been, based on the source term, we could put a maximum dose and assign that to each and every -- maximum exposure, let's put it that way, 'cause the dose would come later -- to each and every claimant.

But let's take the scenario where there is a time period where there were some very rudimentary monitoring measure-- rudimentary measurements taken, and so we would feel fairly comfortable putting a maximum dose on that time period.

Now let's go back further in time and let's say that no monitoring occurred before a certain date. This is very hypothetical. There was no monitoring at all occurred, and we know that the exposure potential was at

least as great as that monitoring period, but we have no basis for what -- what it was maybe above and beyond that, no basis to extrapolate backwards. That may be an example of a type of situation where you know that they were large, you have a period with some very rudimentary data that you're comfortable putting a maximum, but you're not comfortable or it's not with sufficient accuracy to go back in time and put a cap on the upper limit going backward in time. I mean those are sort of the situations that may apply here. I mean there's other situations, obviously, but that's an example of what I might offer. So you could put a maximum at one time period, but you have no idea how great -- how much greater it could have been or the lack of engineering controls may not have been there, so you just can't put a cap on it at that point. It's just not possible.

**MR. GRIFFON:** Right.

**DR. NETON:** And so NIOSH could not come out with a credible exposure model for that time period. That's the kind of situation I

believe we're addressing with this -- this regulation.

**MR. GRIFFON:** But you're -- you're saying -- I mean this goes back to -- to our discussions in previous meetings about accuracy versus precision, I know that.

**DR. NETON:** Yeah, sure.

**MR. GRIFFON:** But you're saying that any -- anything you can cap is basically adequate for a determination of a Special Exposure Cohort.

**DR. NETON:** If we can put a cap on it, it -- it's -- it's not necessary -- it --

**MR. GRIFFON:** I'm sorry, I --

**DR. NETON:** To not put a cap on it is necessary to become a part of the Special Exposure Cohort. If we can put a cap on it --

**MR. GRIFFON:** If you can put --

**DR. NETON:** -- and put a maximum dose on that time period and in fact if we applied it to all cases in that time period -- now it's not a dose, it's an exposure model that would be that -- what is the maximum air concentration, for example, that

could have possibly been in that facility in this five-year period. If we can do that, then it is -- we're not required to, but we could put a maximum dose -- a maximum exposure to each and every claimant in that time period.

**MR. GRIFFON:** Right, and if you can't calculate a maximum, that's the only time --

**DR. NETON:** And if going backwards in time, or even forwards in time, if engineering controls or process streams change that we don't know and we -- and there's no way of extrapolating -- when there's no monitoring data and there's no way to extrapolate into those periods that is reliable, then that may be a scenario where we would -- we would possibly say we couldn't put a cap and would recommend it for Special Exposure Cohort.

**DR. MELIUS:** So is that in your guidelines?

**DR. NETON:** Is that in the guidelines? Not exactly those words, no.

**DR. MELIUS:** Well, we're not expecting you to quote them.

**DR. NETON:** I think that there are a couple of examples that were going to be put in there and I'm honestly --

**MR. KATZ:** Their guide--

**DR. NETON:** -- not sure what --

**MR. KATZ:** The guidelines address -- I mean they really -- they refer to the dose reconstruction guidelines that tell you what to do when you are limited to source -- source term and process information --

**DR. NETON:** If one runs through --

**MR. KATZ:** -- which --

**DR. NETON:** -- the gamut -- I'm sorry, Ted.

**MR. KATZ:** -- which is the --

**DR. NETON:** If you run through --

**MR. KATZ:** -- scenario the (Inaudible) is talking about.

**DR. NETON:** -- (Inaudible) and you end up with source term and you -- you have an idea, and the source term is not there, you just don't know and you don't know about the engineering controls, then that's where -- that's where you're left.

**DR. MELIUS:** But does it say that,

though? I guess --

**MR. KATZ:** Yes. I believe --

**DR. MELIUS:** It seems to me there has to be some posi-- some positive guidance as to when you don't have sufficient accuracy. I mean that's -- at least what I would refer to as sufficient accuracy.

**DR. NETON:** I believe they do address that.

**MR. KATZ:** It's -- but it's not --

**DR. NETON:** We're descriptive in that --

**MR. KATZ:** Yeah, and it's not -- there's -- there's no bright line with one item or another because, for example -- I mean you could have a relatively small amount of source term and not know -- have to know any process information. If it's a relative small -- you could cap doses -- you don't need to know a whit about the process or the environment or anything. You could just do --

**DR. NETON:** But there are some facilities --

**MR. KATZ:** -- (Inaudible) case...

**DR. NETON:** -- that we're saying, you know, uranium metal that may have had some surface oxidation and they processed it for a period -- this is an example -- maybe a week, we could put a surface oxidation model on that and generate the entire amount airborne and probably demonstrate -- you know, I mean assign a maximum dose, and process those dose reconstructions.

**DR. ZIEMER:** One of the issues I think that reoccurs is the use of the word "accuracy", which is probably not being used accurately, and that is -- it appears to me what they -- when they talk about capping the dose, in my mind it's probably very inaccurate. It's a worst-case thing. It's probably not accurate. It's probably very inaccurate. But they're talking about ability to make a judgment on causation or probability of causation and therefore if they have sufficient information to make the judgment, then it's, quote, sufficiently accurate to make the determination. Scientifically it may be very inaccurate, as I see it. The real number is virtually

never that maximum thing. I mean I've seen -- I've seen accident cases where you -- you take a source and it's completely airborne and look at -- look at what a person intakes from that if they're standing right there, and if you said they took in the whole thing, you would be orders of magnitude off. But if it's sufficient to make the decision, that upper cap number, that's -- may be sufficiently accurate. I don't think it's necessarily -- if we're talking scientific accuracy, I don't think (Inaudible).

**MR. KATZ:** But it's -- it's just --

**DR. ZIEMER:** It's sufficiently accurate to make the determination.

**MR. KATZ:** Which means, in effect, that we're assured we're overestimating, not underestimating the person's dose, which means that they'll be treated fairly when it comes to --

**DR. ZIEMER:** Right.

**MR. KATZ:** -- having their probability of causation determination.

**DR. MELIUS:** But fairness is -- meaning that two people working side by side or in

the same area are going to be also treated equitably in that -- that process, and that's what I worry about and that's where I think, you know, having a set of guidance for doing this I think is -- is important.

**DR. ZIEMER:** That they all get the same treatment.

**DR. MELIUS:** They all get the same treatment, so either they're -- that's why I think there's a trade-off between the individual dose reconstructions and the -- you know, and the Special Exposure Cohort side of things, and I think a set of guidelines is...

**DR. ZIEMER:** Let's -- Richard's been waiting to have input in --

**DR. MELIUS:** Well --

**DR. ZIEMER:** Rich.

**MR. ESPINOSA:** Looking at the rule, one of the things that I don't see is the definition of site and facility, and with -- with concerns of the 250 days with contract employees and maintenance employees, you know, I know that we can add 250 days from one SEC to another SEC, but what about

classes of employees that work in multiple facilities? You know, right here it says that multiple -- multiple facility -- EEOICPA does not allow multiple facil-- facility classes, but what about building and construction trades, maintenance workers, RCTs, security guards?

**MR. KATZ:** Exactly, so -- so I mean in their cases, they would -- you know, where they worked at three different facilities, they would petition for each of those facilities, a class in each of those facilities. You have a class in each of those facilities and they worked 250 days over the course of working at each of those facilities, they'd be covered, even though there isn't one class covering all three facilities.

**MR. ESPINOSA:** Okay.

**MR. KATZ:** Do you understand?

**DR. ZIEMER:** Does that answer the question or --

**MR. ESPINOSA:** Yeah, it kind of answers the question. And also the burden of proof over this. For one example, within my area,

TA54, there's several areas of -- of this specific site, but if one -- if -- if one area of the site is classified as an SEC, I don't know how they could prove the 250 days. The burden of proof just doesn't make sense to me on some of this stuff.

**MR. KATZ:** How the individuals when they --

**MR. ESPINOSA:** Well, yeah, or the class --

**MR. KATZ:** -- seek compensation could prove that they were --

**MR. ESPINOSA:** Yeah, or the class of people. Like I'm saying, TA54, you've got area G, you've got multiple areas.

**DR. ZIEMER:** Some areas may be --

**MR. ESPINOSA:** Yeah, one area --

**DR. ZIEMER:** -- SEC and some may not?

**MR. ESPINOSA:** -- of TA54 might be considered under an SEC status, but yet all the employees there are assigned to just TA54, not area G.

**MR. KATZ:** I mean this is -- I mean in fact, this is sort of touching on an issue that you'll see when you read the -- the

internal procedures, but -- but -- I mean we will be working with DOL because they will have to -- when we define a class, they will have to be able to make that operative so that they can make determinations of whether someone is in or not in, based on the information that's available. So we'll be working with DOL to ensure that -- if they can do that.

**MR. ESPINOSA:** And that goes back -- you know, goes hand in hand with my question. You know, I don't see the definition within the rule of site versus facility.

**MR. KATZ:** The rule -- the rule relies on the definitions that are in EEOICPA. It doesn't create its own definitions. What it does have is a footnote explaining that you could have multiple buildings, multiple areas within a site at DOE, for example, and they could all be classified as one facility, come in under one petition.

**DR. ZIEMER:** But they may not, also. Right?

**MR. KATZ:** They may not. It just -- it

depends on the case.

**DR. ZIEMER:** Let's see, Jim and Mark.

**DR. MELIUS:** Yeah, one comment for our own deliberations is I think we need to decide as a Board sometime soon how we're going to handle these petitions and what kind of help we're going to get -- need or require from our contractor. It's something I think that was complicated (sic) in the original contract but I think we didn't have a rule to work off of. But given the lead time it takes to do that, I don't want us in the position of having to delay the process any more that -- than is necessary to -- to work that through, so we're going to have to start thinking about a task order or something that would tie into what -- how NIOSH is going to present their review and -- and so forth so we can review it and -- and facilitate that review.

**DR. NETON:** I would just like to remind everyone that there is a cutoff date for task orders this fiscal year -- new task orders -- and I can't remember, it's either June or July. I can look that up and -- and

have that available, but it's coming soon.

**DR. ZIEMER:** Mark.

**DR. MELIUS:** Take your time on the petitions.

**MR. GRIFFON:** One last bite at this apple with the sufficient accuracy thing. I mean I just wanted to follow up on what Paul said, that -- that actually this upper max is actually very inaccurate.

**DR. ZIEMER:** Yeah.

**MR. GRIFFON:** But you went on to say but it would be the conservative estimate -- claimant-friendly estimate. But when we listen to Jim -- I mean the point I'm making is that that upper maximum, according to the SEC rule, may -- Jim says may -- be used in the individual's dose reconstruction. It may not be used, either. They can use a distribution from zero to that upper maximum. And -- and my -- you know, my point there is that, you know, that's not a very bright line. If you're going from zero to 4,000 rem on an organ dose, accuracy or precision, that's not -- and you know, I did discuss off-line some of the -- the

potential sort of semi-quantitative ways to -- to make decisions on that, but if you're getting a different POC when you use the upper maximum dose versus the distribution that is entered in the individual's dose reconstruction, if you're getting one that's higher than 50 and the other cite comes out lower than 50, is that sufficient accuracy? I guess that would be a way I'd pose it, you know, 'cause I agree with you that -- and -- and not to be completely cynical about this, but someone can come up with a outrageous upper bound on something and -- and just say okay, it's feasible. We can do some sort of dose reconstruction for this class. I'm not saying that would get past our review and all that, but that -- that's just the -- the cynical view of it. You can al-- you can probably come up, in most cases, with a very drastic upper bound to some dose. That -- that estimate -- according to this, if I read it correctly, that estimate of the maximum, even if it's the only thing you have, it doesn't have to go in the individual's dose reconstruction, does it?

I mean it -- you said "may" be used.

**DR. NETON:** Well, it depends on what information we have available. I mean if --

**MR. GRIFFON:** You may have more.

**DR. NETON:** If there's more information for us to estimate a mode, a central tendency of the distribution, we would probably use that. But if there was nothing other than the source term and we knew that some grinding operation was going on --

**MR. GRIFFON:** Then you --

**DR. NETON:** -- there's nothing that would prevent us from saying we don't know anything except there's probably less than 1,000 times the maximum air concentration. I mean that would be what we'd do, but we've done --

**DR. ZIEMER:** And everybody would get that --

**DR. NETON:** Yeah, yeah --

**MR. GRIFFON:** My point there is that --

**DR. NETON:** -- (Inaudible) exposure for --

**MR. GRIFFON:** My point there is if it's so inaccurate, you've got one -- you've got

one assumption that you're making that you think is the worst case, but you're working with so minimal data you may not even be in the ball park then, so maybe --

**DR. NETON:** And that's where the individual -- you know, that's where scientific evaluation comes in, that's where the Board has a contractor to evaluate to determine if we're on the right track, if we -- if we've cut too many corners, that sort of thing.

**MR. GRIFFON:** Yeah.

**DR. NETON:** But there are judgments that are made here.

**MR. GRIFFON:** I think we -- I think -- you know, we want to have an opportunity to weigh in on the procedures, too, because then I think we could -- I think we need to have a little br-- if possible, some -- some slightly brighter lines before we go into the review phase. I mean I'd like to have some better...

**MR. KATZ:** I just -- I didn't get a chance to -- I mean 'cause Jim raised the issue of the Board not getting the

procedures, but that we intend for the Board to have the opportunity to review them, and we express that in the rule. Obviously we couldn't give you the procedures until the rule was published because we were in rulemaking. We couldn't give them to you in advance. We certainly expect that you will scrutinize the procedures and give us any advice you can on those procedures. All we say in the rule is that we will not hold up beginning the consideration of petitions until you're done with your review of those procedures. But you know, everything is going to take some -- some time, so...

**DR. ZIEMER:** Jim?

**DR. MELIUS:** Well, it just -- to that point -- I mean, Ted, I find it hard that it -- suddenly the burden's on the board to suddenly complete something that's taken NIOSH over three and a half years. And while you may think it's a joke, I don't think many of the claimants out there who have been promised an SEC petition process in the original law would consider it to be something to joke and laugh about. And I

think it's a major failing of this program, of NIOSH and of the Department that this process has taken so long to get a final rule, and I would hope we could expedite and get things done quicker in the future.

**DR. ZIEMER:** Tony?

**DR. ANDRADE:** I think the final rule as written is an excellent piece of work. I'm sure that lots of people really sweated over the details on how to come up with it and the internal procedures that will be seen, I'm sure.

But I want to make something absolutely clear here, because it seems like we're just not connecting insofar as the equity that -- or the difference that -- of the procedures that go into dose reconstruction versus what we're going to do with respect to potential Special Exposure Cohorts.

If there is sufficient information to derive from -- sufficient information say on a source term to derive a maximum exposure, then all people who have been exposed to that, barring differences in jobs and other exposures they may have been subjected to,

will be -- are applied that same exposure. Okay? That same -- same exposure is applied to them. In other words, there is equity. There is -- if a maximum can be constructed, that maximum is applied all across. There is no distribution of doses.

When -- believe it or not, when we had more data -- okay? -- when we had more data, not only source information but CAM* information, dosimetry information, et cetera, et cetera, and those data can be attributed to an individual, that's when it becomes a little bit more murky because you can calculate an individual dose that may not be the maximum dose to that person.

So different people under different scenarios, when you have a lot of data, can have different doses, even if it -- even if they're working at the same facility. Okay?

Let's not confuse that -- let's not confuse that issue. I think people are hung up on that, and unless you've done health physics work in the past, I guess it's -- it's hard to comprehend that, but the more data you have, the easier it is to assign a

dose to an individual that may not be the maximum dose that one would assign if all you had was a source term. Okay? I just don't know how to make it more clear than that.

**DR. ZIEMER:** Thank you. Wanda?

**MS. MUNN:** I guess I just felt it necessary to comment that I have not heard anyone making jokes about anything that we have done here. If -- if anyone has done so, it certainly has not been in my hearing. To the best of my knowledge, both staff and the members of this Board have been very serious and very dedicated in their approach to what we have to do.

I appreciate this rule particularly. I know we've all waited for it a long time, and I spent a lot of time going through it since it was made available to us on the web and highlighting items that made the changes clear to me. I'm very pleased to see the process outlined that the Board is going to have to address because it appears that this is what we have been primarily constituted for. Up to this point we have been awaiting

this rule so that we would know how to move into this last -- what I believe is the last stage of the requirements of the law.

So thank you to the staff for getting this to us before this meeting so we have an opportunity to see it, look forward to seeing the procedures. Would seem wise to me that we not allow our imaginations to place us in a position where we are pre-judging what may occur now that the rule is available. I for one would like an opportunity to see what is going to occur now so that we may better evaluate what our actions need to be in the future.

**DR. ZIEMER:** Thank you, then Mark?

**MR. GRIFFON:** Just a -- maybe Tony was -- was pointing to me on that misunderstand-- I don't think I'm misunderstanding the difference between maximum dose and the estimate. But anyway, the -- you know, my point, again, was that -- and I think we can deal with this in the guidance stuff, but my point was that you may have a couple of datapoints that suggest very low exposures for certain people in a class -- or for the

whole class, and one datapoint that suggests a potential for a very high exposure, and then you ha-- then you will have a distribution and -- but is it sufficiently accurate? In other words, there's so little data on either side that is that sufficiently accurate, and this SEC rule says if I can calculate a max, I don't care about the rest, it's sufficiently -- it's feasible -- it's feasible to estimate a dose. How that gets played out in the individual's dose reconstruction from there on is a different issue. But I won't harp on this anymore.

**DR. ZIEMER:** Well, unfortunately we are dealing with a lot of theoretical or hypothetical cases here, and the proof of the pudding will come down to actual cases. And the Board will have the opportunity to look at every one of these and make a determination on the very issues we're all talking about here, and then we will have real data, real situations, real facilities --

**MR. GRIFFON:** Yeah, but I --

**DR. ZIEMER:** -- and I think we can construct a lot of what-ifs that may or may not be realistic. So we are going to have to look at actual cases and determine the extent to which these issues are really problems. And then we'll have to deal with it.

**MR. GRIFFON:** I disagree to some extent 'cause I think we have some real-world experience, and all I'm saying is in the guidelines we may be able to develop some -- some better sort of -- of maybe not bright-line tests but some sort of indicators of sufficient accuracy. And I -- I've thought through some possibilities and I think we should have some dialogue with NIOSH on that in the gui-- you know, maybe as a second draft of the guidelines. That's all I'm saying.

**DR. ZIEMER:** Okay.

**MR. GRIFFON:** The only other point I wanted to raise before we break 'cause I know we've got a break coming soon here, is there's a section in here on the health endangerment. You talk about the 250 days,

but there's also a condition in the preamble part or whatever that talks about internal versus external exposures, and that for internal exposures it'll be assumed all cancers are covered but for external not necessarily the case. Am I reading that wrong?

**MR. KATZ:** No, you're -- you're not.

**MR. GRIFFON:** Give me the interpretation of that.

**MR. KATZ:** There's no -- for health endangerment there's no issue with respect to internal/external doses whatsoever. There's nothing -- there's nothing in the rule, there's nothing in the preamble addressing that.

In the preamble there was a discussion -- which you may be thinking of -- of when the Board considered the issue of feasibility on a case-specific basis of -- of what were real scenarios where it would be feasible for some cancers and not feasible for others. And in effect -- I mean what we discussed is -- is those situations really involve external exposures

where it would be feasible for some cancers and not feasible for others.

But when you're talking about internal exposures, there would be some amount of dose that would get to other organs, even though you can't, you know, quantify very minimal -- it may be very minimal, but since you can't quantify the -- and this is an issue that you actually raised in that discussion. You can't quantify the total dose coming into the lung, then how can you quantify the sequelae, the resulting doses to other sites.

And we acknowledge that in the -- in the preamble and said so --

**MR. GRIFFON:** What I'm -- I'm talking about is this -- I'm sorry, I have this older version, it's page 19 in this older version. It -- as a result --

**DR. ZIEMER:** What section is it? Maybe that will help us.

**MR. GRIFFON:** It's under -- in the preamble, I guess, section (b), feasibility of dose reconstructions, relevance of type of cancer to feasibility determinations.

**MR. KATZ:** Right, which is --

**MR. GRIFFON:** Right. And I mean it says (reading) As a result -- this is after the theoretical discussions.

(Reading) As a result, the scientific finding concerning the feasibility of estimating doses in cases involving internal exposures -- internal underlined, emphasized -- would have to apply to all cancers.

So that led me to believe that -- that the same principle was not --

**MR. KATZ:** In other words --

**MR. GRIFFON:** -- used for external --

**MR. KATZ:** -- feasibility determination -- if -- if we were going about a cancer-specific feasibility determination, it would have to apply to all cancers --

**MR. GRIFFON:** Oh, okay.

**MR. KATZ:** -- but we've taken that out of the rule --

**MR. GRIFFON:** You take --

**MR. KATZ:** -- so it's not an issue.

**MR. GRIFFON:** So it's --

**MR. KATZ:** It's not an issue.

**MR. GRIFFON:** -- (Inaudible) is

straight, I just wanted to clarify that --

**MR. KATZ:** That's just a discussion of -- of the reasons --

**MR. GRIFFON:** A variety --

**MR. KATZ:** -- how our thinking went as to why we eliminated the cancer-specific provision.

**MR. GRIFFON:** Okay, I -- okay, thank you.

**MR. KATZ:** Yeah.

**DR. ZIEMER:** Yeah, Mike.

**MR. GIBSON:** Just a clarification for -- from NIOSH for the record. You know, we've had a lot of talk back and forth here about determining worst case exposure to determine if someone's eligible for the Special Exposure Cohort. I will tell you I am one from the field, I have health physics experience, I've been involved in rulemaking, policy/procedure review, et cetera. Is NIOSH stating to us here now that if they have enough data, whether it's one datapoint or several, to determine a maximum dosage to determine eligibility for Special Exposure Cohort, will you use that

same maximum dosage for their individual dose reconstruction if they're denied their Special Exposure Cohort status?

**MR. KATZ:** If they're -- if they're denied. Oh, and that's where -- there was some discussion here about the difference between maximum exposure and individual doses, those are different. So you would be applying the single exposure model to the situation, but you wouldn't have as a result the same doses to each individual because those doses would depend on other factors, including what type of cancer they have and -- but -- Jim, you want to --

**DR. NETON:** More than likely this would occur in a situation where you've had an estimate of air concentration and NIOSH was able to determine -- it more than likely would not be based on a single measurement, but if we have multiple measurements where we could estimate the maximum air concentration that could have possibly occurred, that air concentration then would be used and people, based on their occupancy time in the area and other factors, would be

-- their internal dose would be calculated using that air concentration that was estimated to be the upper limit, that's true. It could be. It doesn't have to be, but it could be.

**MR. GIBSON:** Could be, so you're not -- that's applying what -- on the record, NIOSH is saying that you won't specifically use the worst-case dose estimate to deny someone SEC status as you will to apply to their dose reconstruction.

**MR. KATZ:** And it depends on whether you have other data to do better than that. If that's the -- if that's the limits of your data, to use that worst-case exposure -- I mean then you're using it. Right?

**DR. NETON:** That would be the last -- would be the last piece of data we would have that -- before we would go to SEC or before we say we can't do it. We have to have something. You know, we're not going to make this up out of thin air. We're going to have to have some kind of data that would substantiate the air concentration in the example I used that we apply. And it

would be up to review to determine if that was sufficient -- you know, was -- did NIOSH have sufficient data to make that upper estimate.

**MR. GIBSON:** I understand that. I'm coming from the back -- back end. If someone applies for Special Exposure Cohort and you go through what data you have and determine a worst-case exposure, say no, this petition doesn't qualify. Will you take that same determination, that highest level, and use it as their dose reconstruction (Inaudible) for the probability of causation or whatever?

**DR. NETON:** I don't know that in the SEC petition evaluation that we would necessarily flesh out the exact details of how would we do the dose reconstruction, you know, down to the model we would use, but we would have to ascribe the data that were available to do the dose reconstruction. In other words, I don't -- I don't think we would do dose reconstructions to say we can do dose reconstructions in an SEC petition evaluation. We will -- we will outline the

type of information that we believe are available to allow us to estimate doses in that cohort.

**MR. GIBSON:** Worst case.

**DR. NETON:** Worst case, yes.

**MR. GIBSON:** So the ans-- if I can get an answer for the record, it's that the estimated dose used to determine whether or not someone qualifies for SEC status is not necessarily the exposure or the dosage that will be assigned to them when you do dose reconstruction. There is a difference.

**DR. NETON:** Well, I think what I'm saying is I don't know that we will ac-- we're not going to actually calculate doses to members of the SEC petition cohort. We're going to describe as clearly as we can the information that we believe is available to allow us to do those dose reconstructions, so -- and that may involve some -- some spelling out of air samples that were available and the concentrations that would be used in the exposure models, so you know -- but we're not going to develop an entire exposure model to -- to

document that we believe we can do dose reconstructions.

**MR. GIBSON:** I understand that. Let me try --

**MR. GRIFFON:** It gets back to the same thing I was discussing. I really think it --

**MR. GIBSON:** Right, I mean there's health physicists discussing it, now I'm trying to say -- you're trying to take -- take a worst-case scenario to see if they qualify or not for SEC. That wouldn't necessarily be the dosage -- if they're denied SEC status, that wouldn't be the dosage applied to them on their dose reconstruction.

**MR. GRIFFON:** Well, you wouldn't necessarily --

**MR. GIBSON:** Not necessarily --

**MR. GRIFFON:** (Inaudible)

**MR. GIBSON:** (Inaudible)

**DR. NETON:** That would be the worst-case scenario, but we may be able to do better than that, depending on what information was available. I'm sorry, I

misunderstood --

**MR. GIBSON:** So there's a difference.

**DR. NETON:** Okay, sorry.

**DR. ZIEMER:** Tony.

**DR. ANDRADE:** Okay, one more time. I think I now fully understand where Mark and Mike are coming from, and I think what -- where Jim is coming from and where we're all having a little bit of difficulty in understanding each other is the following.

If we don't have enough information available on all of the things that normally are considered in a dose reconstruction -- dosimetry, source term, process information, et cetera -- if there is not enough information or that information is very sketchy about the source term and therefore the range of doses that people could have received, then indeed that thing -- that particular situation would point directly to a special cohort status.

**MR. GRIFFON:** But that's not what the rule says. That's my point.

**DR. ANDRADE:** But I -- I think that's --

**MR. GRIFFON:** Well, maybe I'm -- maybe I'm being too cynical, but that's not the way the rule is written. It's if you can get a maximum, it's feasible, you're done. The question I'm grappling with is sufficient accuracy. And like Paul's pointed out, you can get a maximum that's very inaccurate. Maybe in the guidelines -- I'm saying I have some ideas on it and I've -- I've brought these up to NIOSH -- not on the Board, but off-line -- ideas of maybe ways to look at a brighter-line test for sufficiently accurate 'cause I think that -- you know, you can have -- you can have a max-- just to be cynical, you can put that wide distribution out just to say well, we don't want to do an SEC for this group, you know.

**DR. ZIEMER:** Well, folks, we're starting to recycle discussions that we've had a number of times. I think -- I think we all realize there's an issue here that we may have to grapple some more with, but it's going to be harder and harder to grapple with it on an empty stomach.

No, in reality we now -- we do have an evening session. We need to allow some time for a break and for folks to eat their dinner, so we're going to recess until 7:00 o'clock.

Well, I'm skipping site profile status because if we do site profile status tonight, we're going to skip supper -- well, maybe I should call for a motion on which you'd rather skip, but I --

**DR. MELIUS:** The only question I have is does Jim Neton want to present the Bethlehem slides from that -- he has some overheads on -- before the session tonight? Not now, but before the session tonight --

**DR. ZIEMER:** Well, that --

**DR. MELIUS:** -- sort of an up-- an update --

**DR. ZIEMER:** -- would depend on how long that will take. We need to allow time for the public.

**DR. NETON:** Oh, I see, you'd like to have an idea what the Bethlehem Steel --

**DR. MELIUS:** Well, I think -- I think you have three overheads on -- I mean --

**DR. NETON:** I could literally do that --

**MR. KATZ:** Turn the mike on.

**DR. NETON:** -- (Inaudible) minutes.

**MR. ELLIOTT:** Turn the mike on, please.

**DR. NETON:** I'm sorry. I could probably do that in ten or 15 minutes, it's two slides or a slide and a half, so it's up to you all.

**DR. MELIUS:** Do it at 7:00, that's what I'm --

**DR. ZIEMER:** Is there any objection to doing that at the front end for the -- and the -- it would be beneficial for the members of the public, as well.

**DR. MELIUS:** 'Cause it's going to come up and I -- I figure --

**DR. ZIEMER:** Sure. Jim --

**DR. NETON:** I can do that.

**DR. ZIEMER:** -- let's plan on that.

**DR. NETON:** So that would be the beginning of the public -- we're not going to start the public session early. Right?

**DR. ZIEMER:** No, we'll start it at 7:00 --

**DR. NETON:** Fine.

**DR. ZIEMER:** -- and go from there. And then the rest of your presentation we can work in tomorrow. So we will recess until 7:00 o'clock. Thank you.

(Whereupon, a dinner recess was taken from 5:30 p.m. to 7:00 p.m.)

(7:00 p.m.)

**INTRODUCTION**

**DR. ZIEMER:** I feel like you're so far back here, I have to come back and see who's here.

Welcome to the public session of the Advisory Board on Radiation and Worker Health. Actually all of the sessions are public, but this is the public comment session.

My name is Paul Ziemer and I Chair this Board. I want to introduce the other members of the Board. I'll point out to you first of all that the program that we're involved in is administered by four Federal agencies. That may or may not be a good thing. You would have to decide for yourself, but these are the four agencies

involved.

This particular Board works closely with NIOSH, which is part of the Department of Health and Human Services, and we provide our advice to the Secretary of Health and Human Services. So that's the group that we work with closely. The National Institutes for Occupational Safety and Health is part of NIOSH -- or a part of Health and Human Services, that second agency that you see there. But also the Department of Labor, the Department of Energy and the Attorney General's people are all involved in this program.

Now the members of the Board -- they all have placards up here, and I do have their names listed, and these individuals are appointed by the President under the requirements or under the provisions of this particular law that has put this whole thing in motion. The law says that the Board consists of no more than 20 members. We actually have 12 members of the Board. The members include affected workers, their representatives, and representatives from

the scientific and medical communities. And we have that kind of a spectrum of individuals here in this group represented today.

(Pause)

So here are the members of the committee. Larry Elliott is the Federal officer and he serves as a member of this Board, and then the others as you see listed there -- Henry Anderson is not here tonight, An -- we call him Tony, really, Antonio -- Tony Andrade. Tony, indicate who you are -- and I hope you can read these. Tony's at Los Alamos. Roy DeHart, Rich Espinosa, Mike Gibson over here, Mark Griffon, Jim Melius, Wanda Munn, Leon Owens -- Charles Leon Owens, Robert Presley and Genevieve Roessler. So these are the members of this Board.

And finally I want to tell you or remind you of what the responsibilities of the Board are, as defined by law. We have been involved in developing some guidelines that this program uses. Those have to do with what's called the determination of

probability of causation, the likelihood that a cancer was caused by radiation exposure. And also involved in reviewing and assessing the guidelines for what are called the dose reconstructions which are done for individual claimants.

Now the Board itself does not do the dose reconstructions. Those are done by the Federal agencies. But we have had input on developing the guidelines that are used to carry those out.

You also notice that we have a responsibility to assess the scientific validity and the quality of the dose reconstructions. For the Board that is a kind of audit responsibility. We are just getting underway with that. We will go back and select a number of cases that the -- that the agency has assessed, and number of dose reconstructions, to evaluate -- in a sense, audit them and see whether or not we concur with their methodology and their findings on those. But we do not go back and review all of the dose reconstructions. This is a sampling to see if we note any

errors -- systematic errors or other kinds of issues that might arise -- or is the agency carrying things out the way that the rules say that they should. So it's an audit type of function.

And then the third thing or the third main thing on the bullet -- or third main bullet here is the determination of what are called the Special Exposure Cohort groups. They're -- the legislation allows or provides for certain groups to petition to become part of what is called the Special Exposure Cohort, whereby separate individual dose reconstructions no longer would have to be done for those individuals if they so qualified, or groups of individuals. And that process -- the Board is also involved in those determinations.

The rule on how Special Exposure Cohorts -- or additions to what is called the Special Exposure Cohort, the rule on how that is done just came out two days ago, basically. I think it was the day before yesterday. So that process is just getting underway.

So the Board really confines itself to those issues. We do not get involved really directly in people's individual cases.

Now there may be a number of you here today that want to talk about your individual cases, and that is fine. We're -- we typically hear a lot from people around the country about their experience with the program, positive or negative. And the benefit to the Board is not so much knowing what your personal case is about -- although we're glad to hear that -- but it is more to learn what your experiences are with the program, where you think changes could help, what difficulties you might have encountered that might be indicators of bigger problems in the program, that sort of thing.

We are not here to answer questions about your specific cases. In fact we could not do that, because of privacy rules, in an open forum anyway. So if you have particular issues about -- if you're a claimant or a person who is involved in a case, if you have specific questions, you may want to talk to some of the staffers

afterwards and they can follow up on specific things for you if that is an issue for you.

But we -- we do welcome hearing information about your experiences. We can't necessarily answer questions -- you may have some questions, and if you do have questions we will try to find individuals who can answer them for you. But mainly we're here to learn what you have to say.

**BETHLEHEM STEEL SITE UPDATE**

Now before we actually start with your comments, one of the staff people here, Dr. Jim Neton -- Dr. Neton is on the NIOSH staff and very much involved in the dose reconstruction process and the development of site profiles for various facilities around the country. And Jim has prepared some information about the Bethlehem Steel site and that site profile, and we thought that would be of interest to many of you tonight. He just has a few slides about that and we'll use that at the beginning here, and then have the opportunity to hear from you. So I'm going to turn the pointer

and the mike over to Jim Neton.

**DR. NETON:** Thank you, Dr. Ziemer. I just have a couple of slides on the Bethlehem Steel profile. It's my pleasure to be here this evening to talk about what we've been doing on the Bethlehem Steel profile. I recognize some familiar faces in the crowd from the town hall meeting we had less than a month ago here, and I did indicate at that town hall meeting that we're working on this and I'm happy to say that we finished our analysis -- at least of the profile.

I have some other slides that we won't get into this evening. This is more for the public meeting tomorrow, but since you guys were all -- since the general public is here specifically to talk about Bethlehem Steel tonight, we thought we'd go over where we are with the ingestion pathway.

Just as a way of reminder to the Board and some members of the public why Bethlehem Steel is an Atomic Weapons Employer and included in the compensation program, Bethlehem Steel is a facility that obviously

processed steel, but between 1948 and 1952 was under contract with the then Atomic Energy Commission to attempt to take billets of uranium -- big round hunks of uranium -- and roll them, in a very vigorous rolling process with a lot of pressures, into rods -- uranium rods that could be shipped to Hanford and inserted in the reactor and -- and make fuel for the war effort -- or plutonium for the war effort.

During that time frame, this -- '48 to '52 is the time frame that the site is acknowledged to have a contract, and we developed an exposure model for those four years. And we determined that -- the model was an air -- air concentration model. We had no bioassay data there that -- we assumed that 12 rollings took place each of those years between 1948 and '52 for a total of 48 rollings, and developed an air model. And we said this is -- these are the air concentrations that people breath, and the upper limit of the air concentration was somewhere around 1,000 times the maximum acceptable concentration at that time, which

roughly equates something in the vicinity of 50 milligrams of uranium per cubic meter -- huge, huge dust loading. I mean a very thick cloud of uranium dust at those levels.

What's been pointed out to us, and rightfully so, is that we did not explicitly include the ingestion pathway. We did a pretty good job, I feel, of addressing the inhalation of uranium, but there was no model in that profile that talked about what the doses were to the general worker in the vicinity of the rolling operations from eating -- ingestion or -- eating or drinking contaminated material and touching material and transferring it to their -- their mouth. So as I said, the pathway was not explicitly addressed, although we did consider it. And from health physics perspective, usually ingestion pathways are very small as far as delivering dose to the worker. But you know, we do -- we do need to address it.

So to consider this model we assumed that there were three ways that people could ingest uranium in the facility. First is when you inhale material, the lung is pretty

good at clearing particles from your -- from your -- from the lung, you know, contaminants. So you would inhale uranium and your mucociliary latera*, the clearance mechanism of the lung, will clear the uranium up into your throat and you'll swallow it. That is one mode of ingestion. That model is addressed in the ICRP model that we use, the lung model that's a standard model for our process, and so we didn't have to address that. That was inherent in our analysis.

The second two issues weren't though, the settling of airborne uranium on food or drink, and then the transfer of contaminated surfaces from the hand. One touches a contaminated surface and goes to your mouth and will ingest a certain amount of uranium.

What we've committed to do, and we do this with any profile and dose reconstructions that we perform, if we do a reanalysis, we will go back and evaluate the previously processed cases that had been denied by the Department of Labor to see what effect that new pathway or that new

analysis may have on the compensation decision, or in our case, on the dosimetry calculation and ultimately Department of Labor would make a re-evaluation and decision on that new pathway for compensation.

Okay. Just briefly -- and this is only the second slide I have so I'll try to be fairly brief so you guys can have time to ask questions, but settling on the food or drink was modeled using continuous settling into an open container. We assumed that a person would have a coffee cup or some type of beverage container and the uranium in the air, as I mentioned, went up to 1,000 times the maximum allowable air concentration. So we took that exposure model and based on what we know about the settling properties of uranium -- it has a certain velocity that it settles down on the surfaces -- we assumed that this container sat out in the work place the entire day and was open to the atmosphere and accumulated all the uranium that was in the air that would settle into the container, and then assumed

that 100 percent of the settled material in that container was ingested.

Now this is a kind of a nice analysis because we don't have to worry about how many cups of coffee a person drank. We just assumed that that coffee cup was open to the atmosphere and the air concentration for the entire day, so that's the first model we ran.

The transfer to hand allowed for the ingestion of ten percent of the uranium transferred to the hand. In other words, if you touch a surface and it's on your hand, we assumed that ten percent of what contaminated your hand became ingested. It's a fairly, we believe, favorable -- claimant-favorable analysis. We found some literature indications that one percent may be more appropriate, but we wanted to be conservative and we chose ten percent.

We also -- this model also was based -- and we -- on the settling of the uranium in the air, this up to 50 milligrams per cubic meter over a full 24-hour day, and assumed an equilibrium concentration -- in other

words, what settled and what's removed, there's a -- there's an equilibrium value that would be eventually established that the air -- air concentration would -- would account for, and the only removal mechanism that we considered. We didn't consider housekeeping or, you know, dispersion by wind or resuspension. We just assumed the only -- the only mechanism for removing that material from the surface was contamination of the hand. So the hand is constantly picking up this ten percent of the material that's deposited.

The other piece of information that's relevant is that when you ingest uranium, only a certain percentage of it becomes absorbed by the body. The rest of the material will be excreted in the feces. There are two choices in the models that we use. One says that only .2 percent -- two-tenths of a percent is absorbed by the gastrointestinal tract, and the other model says two percent. The choice is depending on whether the uranium is in a very insoluble form or slightly more soluble.

There are indications that Bethlehem Steel -- this may be -- is more likely insoluble uranium, but we chose the more claimant-favorable value of two percent, meaning two percent of what a person ingested was absorbed and 98 percent would be unabsorbed and passed through the body.

The end result of all this -- this is documented in a Technical Information Bulletin that we've incorporated into the Bethlehem Steel profile. It is out there on our web site for viewing and you can look at the -- the mathematical model that we used to do this. But the end result is, with these two pathways taken into consideration, it works out that about 20 percent of the air concentration -- the value ingested is equal to about 20 percent of what is in the air concentration per cubic meter per day. So that's what we've assumed in this model.

We have gone back and looked at the -- a couple of cases. We have not completely finished the reanalysis, but we've looked at a couple of the claims that were pretty high. As some of you know, there were some

that were in the upper 40 percent range for probability of causation. We've looked at those and there's been very little effect on the change in the probability of causation calculation, primarily because the dose that we assume from the air concentration model overwhelms the dose that is a result of this additional ingestion pathway that we've added.

If you think about it, at the upper end of the distribution we are having a person inhale air that has 50 milligrams of uranium per cubic meter. And with the -- if the cancer is not in the lung but an organ distant from the lung, we assume that that material is fairly soluble and rapidly clears to the other organs, so a lot of that inhalation ends up going into the bloodstream and circulating through the other organs. Where this model allows for some ingestion, but much smaller amounts of -- a much smaller degree of this material reaches the body than via the inhalation pathway that we modeled previously.

I'm not comfortable right now saying

that this will not change any claims that have been processed thus far, but our original suspicions are that this would not add much dose and would not likely change many claims appears to be well-founded. But I will caution you and say that we're still looking at this and I can't say -- in this program -- you can't say with any certainty until you look at all the data, and so we'll be doing that in the next week or so and notifying the Department of Labor of any cases we believe that it may have affected to be compensable. We will write this up in a program evaluation report -- this is standard practice for us. When we do a reanalysis like this we document this and publish it -- put this out on our web site so it will be available for viewing by the general public, as well.

With that, I think I'll stop, and if there's any brief questions, I'd be -- if there's time -- I don't know, Dr. Ziemer, do you want to answer any questions or --

**DR. ZIEMER:** Any questions from the Board we can delay till tomorrow, but if

anyone in -- amongst the general public wishes to ask Dr. Neton a question on what he just talked about -- yes, sir, please approach the mike and you'll need to state your name for the record.

**PUBLIC COMMENT**

**MR. KOCHANSKI:** My name is John Kochanski. I'm from Niagara Falls, New York. My father worked for Carborundum, a NIOSH (sic) site. I would like to know the expertise of NIOSH in detecting radiation? How long has NIOSH been doing this, and what is their expertise? Do they have scientists from MIT or Harvard? Do they have geiger counters? Do they understand what radiation is and have they been to the sites to see if there's still radiation today because all the buildings are sitting there. What is NIOSH's job? It's to determine if this caused death. There is sites that are still there. They have radiation -- residual radiation in them and there's tight neighborhoods, there's articles of high cancer rates. It's not only the workers. It's everybody who lives in the area

forever. What is the life of radiation? It doesn't go away in one day. You have a lot of work to do. Please, if you need money, if you need more workers, you will get it. And I would like to know why I wrote a letter to NIOSH five weeks ago about my father's case and I didn't get any information in five weeks. If you need someone to answer your mail, maybe you can hire them. But radiation is exact. There's a lot of experts that you can consult. There's a lot that you can do. These are neighborhoods. These are poor people. We don't want to see the spilling of radiation forever. Has the EPA even been contacted about these sites? Thank you very much. And by the way, my father was in the Pacific Theater. He couldn't go to college. He didn't have the money. That's why we're standing here. Have a good day.

(Applause)

**DR. ZIEMER:** Thank you very much. And in terms of responding to the letter, I think we can ask the staff to follow up -- they have the name -- and find out that

particular thing.

Also, I would point out to -- to the gentleman that in fact NIOSH and their contractor, Oak Ridge Associated Universities, have in fact over the past couple of years hired many of the top health physicists in the country to assist in the program. So indeed they have many, many experts, including Dr. Neton himself, who won't tell you this, but he is a very well-respected expert himself in these areas.

We have received a written letter from Elsie Owens, a letter which included a number of questions for the NIOSH staff. I think a letter which Ms. Owens did not wish to have necessarily read in the public arena here, but her letter has been made available to the NIOSH staff and they will be addressing, Ms. Owens, your questions.

I do want to give you opportunity, though, if you have any additional comments or questions that you want to raise with respect to the letter, which we are having the staff follow up on -- Ms. Owens or the individual accompanying her, do either of

you have some additional questions you want to raise?

**MS. OWENS:** (Off microphone) I can't stand up.

**DR. ZIEMER:** Yes, could we bring --

**MR. ELLIOTT:** Take the mike to her.

**MS. OWENS:** (Off microphone) (Inaudible) hear me from here?

**DR. ZIEMER:** We'll take the mike or the lavaliere mike. Just a moment and we'll bring the mike to you there.

(Pause)

**MS. OWENS:** Hello. What I'm wondering if on the extension of the time frames where the Department of Labor had the cutoff date as 1948 for workers at Hooker Chemical Company and my husband started there early 1950, and I don't think any cleanup was done at that time, that there was a lot of residual left there, and I -- to this date I don't even know if any cleanup was done there. Do you have anything on -- comment on that?

**DR. ZIEMER:** I don't see any of the staff jumping to respond, but we will

certainly be able to check on that and --

**MS. OWENS:** And also Louise Slaughter from Niagara Falls and Schumer were -- had taken to Washington to try and get the cutoff date increased to two to four more years, and I haven't heard anything more on that.

**DR. ZIEMER:** Representative Slaughter's office had someone here earlier today. I don't know if she's still here or not.

**MR. ELLIOTT:** She's left.

**DR. ZIEMER:** She's left, okay.

**MR. ELLIOTT:** Let me --

**DR. ZIEMER:** Let Mr. Elliott respond.

**MR. ELLIOTT:** Yes, ma'am, with respect to the cutoff date, that is not decided by NIOSH. That's a decision that's made jointly between Department of Labor and Department of Energy, I believe. You certainly can avail yourself of your Congressional support, though, to seek that change, I guess. But NIOSH has no control over the cutoff date.

**MS. OWENS:** (Off microphone) Who does?

**DR. ZIEMER:** Well, Department of Energy

--

**MS. OWENS:** Oh, the Department --

**DR. ZIEMER:** -- and the Department of Labor.

**MS. OWENS:** Oh, and you don't know if anything has -- if that's been brought up at all?

**DR. ZIEMER:** We do have a Labor representative here.

**MS. MOSIER:** Yeah, I'm from the Department of Labor, Roberta Mosier. The dates that we use for these claims is based on the wording that is in the Act, which defines covered employee as someone who was working at a covered facility during the period of time when they were performing work for Department of Energy. So it's our interpretation that absent legislative change, without the law being changed, we would not be able to cover someone who only worked after a covered -- after a period when DOE work was being done. So at Hooker, if -- you know, the work for Department of Energy stopped in 1948. Even if there were residual contamination, the way the law is

currently, we do not believe that we would be able to extend coverage.

Now I know that there have been a number of legislators who have been working on legislation to make a change, to cover people during a residual contamination period. But that hasn't -- you know, it hasn't been passed yet.

**MS. OWENS:** Was that ever cleaned up?

**MS. MOSIER:** Was it -- I -- I don't -- I don't know that information. That's probably in the residual contamination report, I would think, isn't it?

**MR. ELLIOTT:** Yes, it would be, but I"m -- and I'm sorry, I don't -- don't remember what Hooker -- our entry on Hooker Chemical had to say, but it's -- we'll -- we'll work to get you that answer.

**MS. OWENS:** I was reading in our Niagara Falls Gazette that so far Hooker Chemical, Linde and none of those cases have been settled, and I was wondering, is there some reason -- it said they -- none of the -- anyone from Niagara Falls has been settled?

**MS. MOSIER:** Right, the reason is most of those claims -- there are some that -- where there have been decisions and those are mostly the ones that were not eligible because they worked outside the covered periods. The rest of them have been referred to NIOSH for dose reconstruction. And since they don't have completed site profiles for those locations yet, we haven't gotten them back from NIOSH. So once -- once they've finished the site profiles, we'll be able to -- Department of Labor will be able to make a decision on those.

**MS. OWENS:** I understand they were cutting a lot of that stuff -- this was for -- during the Manhattan Project --

**MS. MOSIER:** Uh-huh.

**MS. OWENS:** -- for Hooker and other companies, and disposing of that material in Model City, waste. You know anything about that?

**MS. MOSIER:** No. No, I don't, sorry.

**MS. OWENS:** Lake Ordnance, that's --

**MS. MOSIER:** Okay.

**MS. OWENS:** -- LOOW --

**MS. MOSIER:** Right, right.

**MS. OWENS:** Yeah, that's where it was dis-- that's in the Model City.

**MS. MOSIER:** Okay. Right, okay.

**MS. OWENS:** You don't know of anything --

**MR. KOCHANSKI:** (Off microphone) Does the Department of Labor have any labor law --

**DR. ZIEMER:** You'll need to approach the mike if you have a question. And also we didn't get your name here so we can --

**MR. KOCHANSKI:** My name --

**DR. ZIEMER:** -- follow up on your other question, so if you would repeat your name for Mr. Elliott.

**MR. KOCHANSKI:** My name is John Kochanski, K-o-c-h-a-n-s-k-i, long Irish name.

**DR. ZIEMER:** Thank you.

**MR. KOCHANSKI:** Now for the woman from the Department of Labor, have any labor laws been violated? Under Roosevelt's New Deal there were stringent laws that applied to the safety of the worker. Has the Justice

Department looked into the facts of unnecessary risks to employees? You have laws. You are with the Labor Department. There are clear-cut laws and if you would send me a response, I would be very interested to know. My father didn't see his 60th birthday.

**DR. ZIEMER:** Thank you. Now the next person I have on my list is Ralph Krieger or -- is it Krieger?

**MR. KRIEGER:** Yeah.

**DR. ZIEMER:** Yes, Ralph, who's with PACE and from Alden, New York.

**MR. KRIEGER:** (Off microphone) It's too bad a lot of people (Inaudible) my wife (Inaudible) dose reconstruction, but the first thing I want to ask the Board (on microphone) I'd like to a have a round table discussion and a Linde site profile. I'm requesting you out of the Board.

**DR. ZIEMER:** I'm sorry, restate the question.

**MR. KRIEGER:** I -- it's not a question, it's a request.

**DR. ZIEMER:** Request to --

**MR. KRIEGER:** Respectfully given, we would like a round table discussion and a Linde site profile.

**DR. ZIEMER:** A Linde site profile.

**MR. KRIEGER:** As a matter of record.

**DR. ZIEMER:** Thank you.

**MR. KRIEGER:** This afternoon I listened to a number of issues that were brought up about dose reconstruction and one of the things that they came -- along the line and I have an article here that I got out of one of -- one of the books that I get from the Congress, and the Secretary of Health and Human Services, in accordance with section 3513, 21 specified cancers. Specified cancers means the following -- and it goes down to the bladder, bowel and brain, you name it, all the way down. But one of the ones that came up to mind that came today that was in discussion was that the possibility of prostate cancer being eliminated. My question is, being that the prostate is located next to the cayunes (sic) and the cayunes is very susceptible to cancer, which organ is -- is -- is -- organs

would be more susceptible, prostate or the cayunes?

**DR. ZIEMER:** We probably need a medical doctor to answer that, but the organ's location itself is not the determiner of susceptibility. I believe I'd be correct to -- as --

**MR. KRIEGER:** When you're being exposed -- excuse me, sir. When you're being excused to all the irradiation elements -- gas, because it's decaying product, and the radi-- radiation that's coming off, and the dust, you're being exposed to all the elements of nuclear contamination -- gamma radiation, for one. And we know what the gamma radiation was at Linde because our X-ray technicians put down a film on the floor with a lead pencil and covered it. The next day it was exposed. That was in building 30.

Now another issue that you brought up that was discussed here, Department of Labor kind of said that they didn't have any information on this. I don't know if they got this report. This is kind of an older

report, not this year, October of 2003 by Louise Ginzbergen*, MD, MPH, director, Trinity Engineering Association, Cincinnati, Ohio, report on residual radioactive and beryllium contamination at atomic weapons employees (sic) facilium -- facilities and beryllium vendor facilities. This document has all the sites. Many of them are marked out. Linde's marked here; Chandler Street, which did the barrier product -- barrier development for Oak Ridge; (Inaudible) Products and it was in Buffalo, New York; Utica Street Warehouse where they warehoused it. And then we come to the Linde site in Tonawanda. This is your document by my -- Congressman sent to me.

Linde Ceramics Plant, Tonawanda, New York, 1940 to 1950, DOE. Then it's got 1996 on there. This document-- this documentation reviewed indicates that there is a potential for significant residual contamination outside of the covered period in which weapons-related production occurred, 1940 to 1997. Well, they're still on the site. They're still cleaning it up.

Probably won't have it done, if they're lucky, by 2007.

Since the beginning of the first of this year, six of my men, my former members, have come down with cancer, were operated on, two of them are dead since the first of the year. As of today, one of my best friends, who worked with me for the organization, is in the hospital today being operated on -- which makes seven so far this year. That ain't counting last year, seven. The year before that, the year before that, the year before that, the year before that.

It's ironic, as I listen to you talk today, the Board, discuss this dose reconstruction where most of the men worked in secrecy -- absolute secrecy. You opened your mouth, you were gone. Absolute secrecy. Very few people at Linde ever wore dose badges 'cause they were afraid if they wore the dose badges they would give away the secret 'cause other people -- the employees -- want to know why they were wearing dose badges. This discussion on dose reconstruction is the most ludicrous

thing I have ever heard in my life.

(Applause)

And I'll tell you what, today you heard that big loud noise in the building? That was General Groves turning over in his grave. For the information of the public, General Groves was in charge of the Manhattan Project. From the day he started to the day the bombs were dropped was three and a half years. This program was instituted in Washington in the year 2000 and it hasn't been completed yet.

(Applause)

And that's a damned shame to the veterans that worked and came back after the wars, and I'm talking World War II, World War -- the Korean War and Viet Nam, that came back to Linde and other sites. Not just to Linde sites, other sites to work -- Carborundum --

**UNIDENTIFIED:** Hooker Chemical.

**MR. KRIEGER:** -- came back to work --

**UNIDENTIFIED:** Carborundum.

**MR. KRIEGER:** -- in a site that they didn't know it was left contaminated. Or

when they asked questions, they said don't worry about it. That's what they told us at Linde when I was president here, don't worry about it, it ain't going to hurt you -- as I was watching the bodies pile up.

It's a damned shame that General Grimes (sic) could create three nuclear bombs and we can't even get our own people taken care of.

**UNIDENTIFIED:** Very good.

(Applause)

**MR. KRIEGER:** Thank you.

**DR. ZIEMER:** Thank you for your comments. Let me point out also, in -- there's a lot of frustrations on many of these things. This -- this Board of course is trying to do what it can, as mandated by law. We are not able to address all the issues. Those that we're responsible for, we are trying to address to the best of our ability.

Sir, we have some other people that are before you, and I'll give you the mike again at the appropriate time.

We have Linda Burgess from Bethlehem

Steel, who's a resident of Lancaster, New York is next. Linda?

**MS. BURGESS:** Good evening. Thank you for the opportunity to speak with you. I speak on behalf of my mother. My father, John Cruiser*, was a brick layer in the hot gang at Bethlehem Steel from '48 to '78. On July, 1987 he was diagnosed with pancreatic cancer and he died 15 months later. He was 63 years old. He was a husband, father to three of us, and grandfather to six.

He served in the Army during World War II. He fought in the Battle of the Bulge and received two purple hearts. He survived one war, only to be sent into another, the Cold War. Unknown to him, he worked with uranium in the furnaces of Bethlehem, which caused his death.

We applied for compensation to the EEOICPA in 2001 and were subsequently denied. Probability of causation that killed him was 3.13 percent. Since the time that my mother's claim was denied, I have had the opportunity to study the matrix for Bethlehem Steel. I have many questions

regarding the dose reconstruction and that document. Reports indicate that all work was done between '49 and '51. But reports also indicate that seven additional rollings took place in 1952. I also have a letter from Paul Kasanovich*, compensation agent for Labor Union 2603, stating that in 1955, for a period of six to eight months, one day a month the ten inch bar mill rolled steel rounds of the uranium lead content for the Atomic Energy Commission.

The matrix determined that the number of exposure hours per year, by assuming 12 ten-hour work days per year for the 1949 and '50. That is without any documentation regarding rollings. Yet the same assumption is not made for 1955, when rollings were also reported. If the assumption can be made without documentation for '49 and '52, why isn't the same assumption made for '55?

The dates of the rollings are listed in the document. In documents obtained from the Department of Health and Human Services I discovered an experimental rolling that was not listed in the matrix. This rolling

took place on November 17th, 1951. Perhaps the reason that it was not listed was that it was canceled because there were not enough good billets made. Out of approximately ten ton of conditioned billets rolled, only three ton of billets were produced. There is no record regarding the other seven ton of uranium ore. That's seven ton of missing uranium ore.

I also have documents from National Lead Company of Ohio reporting on the rolling of 222 uranium billets at Bethlehem on April 12th, 1952. It states that round billets lose an average of six pounds per billet. The square ones, however, because they're harder to roll, they lose an average of 11.5 pounds. Now since I don't know whether each billet was square or round in Bethlehem, I can't for any certainty tell you how much uranium was lost, but if you take the 1,637 billets that were rolled between April 26th and -- April 26th of '51 and September 22nd of '52 and you double that, because in 1949 and 1950, that would be 3,274 billets for a four-year span.

Between six and 11.5 billets were lost -- pounds, excuse me -- were lost per billet, so the loss would range, for the years 1949 through '52, from 19,644 pounds to 37,651 pounds of uranium ore lost. That's not recovered. That's lost uranium.

In addition, the 1955 rollings were not accounted for. Based on Mr. Kasanovich's letter, approximately seven rollings took place. He said six to eight, but I'm going to be government-friendly and, you know, give you the seven. If we take six -- 1,637 billets for a two-year period, that's 24 rollings, this averages out to 68.5 billets per rolling. We can estimate that there were 475.5 billets rolled in '55. The loss of this uranium then ranges from 2,853 pounds to 5,462 pounds. So the total loss of uranium is 22,497 to 43,113 pounds. That's lost, not recovered.

In the matrix there were several assumptions made. One of them was that there were no records at Bethlehem, so they used Simonds Saw. This assumption was made because the air quality was better at

Bethlehem than at Simonds Saw. But Simonds Saw was production and Bethlehem was experimental. Now if you've ever made a cake and you're experimenting with it, you know that when you do it, it makes a mess. But if you know what you're doing, you don't make a mess. Now they were experimenting on this, so my assumption is that they made more of a mess and lost more uranium.

At least 24 various assumptions are made in the scientific document. If you are assuming most of the conditions, then there are several assumptions missing. My father's dose reconstruction never took into account many of these items. They assumed a ten-hour day. He worked double shifts. He ate on the job. There was no cafeteria for the men to go for lunch. He took his bag lunch. He sat down, he ate on the job. He used to tell us that the iron ore dust would get into the food. Little did he know that it was uranium ore and not iron ore.

Also not noted in the dose reconstruction is the fact that his clothes, hands and shoes had uranium ore dust all

over. Again, he was exposed to more uranium -- more radiation than is accounted for in his dose reconstruction.

My father met all the regulations regarding exposure dates and onset of cancer. My mother should have automatically received compensation. But the Department of Energy is focusing all their attention and assets to prove that he could not have gotten his cancer from the radiation contamination on the job.

The matrix makes many assumptions. Perhaps one of my own that I can make, out of 15 men who worked in the hot gang, 13 of them are dead from cancer and the other two also have cancer.

Oak Ridge Associated Universities were awarded a contract for $70 million to do the constructions. MJW in Williamsville got $20 million to do the Bethlehem Steel matrix. Their entire focus from the beginning of this process has been put together scientific facts to deny my father was exposed and that my mother is entitled to compensation.

The spirit of the law is that compensation be given to those who unknowingly gave their lives for their country. My father survived World War II. He couldn't survive the World -- the Cold War. I truly believe that the matrix and the dose reconstruction are flawed and should be nullified, and I continue to search for answers to my questions. My father was not a quitter, and neither am I. I will get the answers. Thank you.

(Applause)

**DR. ZIEMER:** Thank you very much. Then I have Reverend Jerome Livingston, Bethlehem Steel Action Committee, Buffalo.

**REV. LIVINGSTON:** Yeah, I'm glad you gentlemen came here today. As I listened to the presentations today, that's where I pulled my questions from. I listened to Professor Neton when he gave -- when he did about the site profiles this morning, and he depends on records from Bethlehem Steel that don't exist to make up the dose reconstruction.

Then I heard Ms. Mosier from the

Department of Labor. When she got to page four of her presentation, she said we can produce information, and questions the real validity and the amounts of radiation that the workers have been in touch with.

Then when Mr. Calhoun gave his presentation about the dose reconstruction, he got to page five of his handout and he said the sites that -- providing data for the dose reconstruction and Bethlehem Steel wasn't on that list. Then he went to page six of his handout and he said the -- the next tier of sites that were producing information, and Bethlehem Steel wasn't on that list. And so if Bethlehem Steel is not on the list that's providing data, how can you actually give a good dose reconstruction with produced data or with actual data, this is the question.

But then I went on and I came in contact today with a report that was written in 1985 and the name of the report is the Elimination Report of Bethlehem Steel Corporation to the U.S. Government. And in that -- in that document, when it gets to

the section that says site description, it says the ten inch mill was in use in August of 1976 and has been taken out of service and dismantled. Well, I can take you out there now and that mill is still standing there, and there are people working in that place. So if you are using documents from Bethlehem Steel that are not reliable and they lied to the government that we have those copies of this information, how can you use some produced and not qualify -- you know, Bethlehem Steel is bankrupt, and that property has been razed, so how can you use information that does not exist? Are you producing information to make these dose reconstructions? Evidently. This is the questions that I would like to have you answer.

(Applause)

**DR. ZIEMER:** Thank you very much. The gentleman approaching the mike, we can take you next.

**MR. KOCHANSKI:** My name is John Kochanski. I would like to know if I could get access to every single page of your

records that you have in so-called boxes all over the country. I am a U.S. citizen. I have rights. If it takes a Freedom of Information, I would like to -- I would like to see a copy of each paper, just for my own well-being, to know what information you are acting on. Dose reconstruction is a very fancy term. It sounds official. This is radiation. Go to the person's burial spot, check the radiation in their bones and you won't have a problem. Have a good day.

**DR. ZIEMER:** Thank you. I have no additional names of people that have signed up, but we can certainly take additional comments. Sir.

Oh, I also have one on -- is this Mr. O'Brien?

**MR. O'BRIEN:** My name is Eugene O'Brien.

**DR. ZIEMER:** Yeah, I do have you.

**MR. O'BRIEN:** And I was with the Reverend here before at a previous meeting, and during that meeting I was -- I was amazed. And I'm not blaming you people, but I was amazed that Bethlehem Steel got away

with it, that they said the mill was dismantled. So therefore, you didn't go any further with it. It was eliminated because it was dismantled. But now it's still there. You have workers from a new company that's taken over that plant and the stuff is still there.

My discussion last time -- I think it was with you, sir -- was that the stuff is on the beams. It's on the floor. They cleaned up the floor. They -- it's like you -- housecleaning, your mother just didn't clean up the floor here. If there was a second floor, you went upstairs and cleaned that. And if there was a third floor, you cleaned that. On the cranes that were going overhead, they all had this dust on them. That's the second floor. The third floor has got like large, 24-inch beams crossing that whole mill. Nobody's ever checked that.

They said that they cleaned after every rolling. They only did it on weekends and then they were ready for the crew to come in, it was all cleaned up. How could that

possibly be? On Monday morning they had a crew in rolling so-called regular steel. I just -- and the people who were handling that steel, did anybody ever pick up -- they were -- it's a hot mill and it's reverse -- wasn't a reverse mill. They had to turn them.

Their instrument they had -- the catchers they called them -- those are contaminated. Nobody's ever said a word about that stuff, not a thing.

Now we're talking about a walk-through. What's the sense of it if you're not going to do anything about it? If this company that has workers there now -- because I have a nephew that is working there now. I called him up and I asked him, are you using the ten-inch mill, the old ten-inch. Well, yeah, he said, we -- all our motors and stuff are over there. I said have you ever gone over and -- get your motors out? He said yes. I said you ever notice any dust coming down? Oh, a lot of it. So the dust has been up there all these years and nobody has looked up to the heavens, never in the

rafters, nobody's looked up at all. That's my opinion, because Bethlehem Steel lied. They out and out lied and said that the mill was dismantled.

So instead of this going -- it could have gone into a -- a -- I don't know what you call it, but we wouldn't have to go through all this had it been classified like all the rest. But no, Bethlehem said it was gone, therefore they stopped. So then they -- then they turned to dose reconstruction and it -- we shouldn't have done -- they should never have been. I mean that's my opinion. You tell me I'm wrong? I mean I -- I can't see where I am. But I -- I'm saying you've got men working there now.

May not -- it's not in the mills, but I also will back up what this woman said. I know a guy that worked there. I gave the name on some of the papers I filled out -- Bill Nysbeth*, his name was. He worked down there -- I was electrician. We worked all over the place. When I got laid off -- actually it saved my life. I got laid off on a disability, so I'm glad I'm out of

there. But he had to work in that bar mill, in the new one. I said did you ever get into the old one? Yeah, all -- dust all over the place. So it's still there and you've got workers -- I have a nephew that went over there. He's working there now. He told me well, yeah, we go over there and pull the motors out. I said do you operate the crane? Yeah. Everything is up there. But they didn't tell you people, so therefore you're treating this as a case different than any -- the other ones. Am I right or wrong?

**DR. ZIEMER:** Thank you.

**MR. O'BRIEN:** I don't get an answer.

**DR. ZIEMER:** No, I say I don't know. We're hearing it, and we -- we...

**REV. LIVINGSTON:** One other thing, Dr. Neton is a solid scientist. That's not to be quibbled with. Mr. Calhoun is a solid individual in the work that he does. In the dose reconstruction that I have a copy of from my father-in-law who passed away who worked there during the covered periods, there are 27 times in the dose

reconstruction when the word "assumed" is used. Any scientist worth his salt will not put his name on assumptions. Anybody knows basic science knows this. But we are putting people's lives under assumption and we know -- I just told you that the information that you got from the -- the Federal government received from Bethlehem Steel was an out and out lie, and it was a classified document, which you can't get a copy of. So if they are giving the Federal government classified documents that are a lie, what kind of information are you using to protect these people's lives? The information that you give them might let them give accurate dose reconstruction with the information, but the information is faulty. If you're going to do dose reconstruction, you ought to do it right. That's...

**DR. ZIEMER:** Thank you.

(Applause)

**DR. ZIEMER:** And let me affirm to you that the Board believes exactly what you just said, it needs to be done right. We --

we are all -- all struggling all over the country with information and how to evaluate it and its validity, so this is not an issue that is strictly Bethlehem Steel. It's an issue everywhere. The staff, NIOSH, is doing its best to try to ascertain the validity of that information. And insofar as we're able to determine that there's better information -- and sometimes that better information comes from folks such as yourselves -- that we -- we can learn some things that perhaps is not -- are not in the official records. So many times these -- what seem to be small pieces of information lead to revelations, if I might call it that. But I can assure you that the folks that you're talking to want to get at the right answers. It's not always easy.

I have another person who has signed up and then I'll come back to -- I may have missed Ed Walker from Eden, New York. Ed -- yes.

**MR. WALKER:** Well, I signed up first, and I kind of wondered if -- maybe they don't want me --

**DR. ZIEMER:** I'm trying to be Biblical here, the first shall be last.

**MR. WALKER:** Well, my name's Ed Walker and I'm with Bethlehem Group, the action group, and there's about -- I believe around 200, and I'm one of the claimants. I'm a survivor claimant. I've got cancer. I got it in the year 2000 and I'm going to kind of briefly go over how I looked at this thing.

You're doing a good job in what you're doing. I -- I was down to Cincinnati last week and I was so impressed and it was a great -- I got a lot of information from it, so that was great. But I'm going to just kind of briefly tell you what -- how, as a claimant, and many of the people that I represent that I've talked to have the very same -- same situation as I had.

In 2001 we were told -- we heard on TV that if you go sign up, you could get -- if you had cancer and you worked at the prescribed time, that you could get compensation. So I called up, everything went fine. I went in and I signed up. I worked with a group at Bethlehem at the

prescribed time, from '51 to '54, and I worked with the special -- with Linda's father in the hot gang, and I was 18 years old. I'd just come out of school. And it was about 15 of us in this hot gang and we worked on specialized -- any place there was a burnout or nobody else would go, we would get called in to patch the holes and work on hot furnaces, whether it be in a bar mill or the coke ovens, wherever it would be.

Well, we've looked up -- there's another fella and myself that are alive. Norm isn't here tonight. I tried to reach him, I think he's out of town, but him and I are the only two left on that -- on the gang that worked steady in this hot gang. And we've tried to find the other 15, and from everyone that we've talked to -- there was -- they've all died of cancer. And when I called Norm to be my witness, he says well, why? And I says well, there was uranium at the plant when we worked there, Norm. And he says you're kidding, and I says no. And he says well, why are you, you know, concerned about it? I says well, I've got

cancer. And this was like -- just a little over a year ago. He says Ed, I have cancer, too. So that's the first I knew that Norm had cancer after these 50 years. So he signed up, by the way.

And I worked with a lot of these heroes that came -- came from the war and fought for the country. I was 18. There was one fella that fought in Corregidor. He was captured by the Japanese. He ran around in the jungle for two -- he escaped from the Japanese, ran around in the jungle for two years. And I told this to Mrs. Clinton -- Hillary Clinton when she was up, and she was quite moved by it, and I worked with this fella and he was shell-shocked. Obviously being chased around the jungle for two years before he escaped, he was shell-shocked.

And I sat down at the plant, in the plant that we worked in, and I was talking to him and two railroad cars clanged together, and this poor fella sat right up and the sweat poured off his face. I knew -- I knew what I was dealing with in that and I felt so sorry for that man to come back,

fight -- and his whole life he was -- he was like that. He was just -- he was just a physical wreck, really, but he -- he could work and he had a family. He had to work. And to think that the government put somebody like this, never told us there was any uranium there, there was -- there was never any badge. There was never any mask. There was nothing. When we went to work on these hot jobs, we worked with asbestos, so naturally -- you know, I -- I'm very moved by these veterans and I know -- I talked to Larry and he was in the service and he knows what it's all about.

But anyway, we signed up with -- a lot of other people went and signed up at that time, and I felt there should be no problem working with the group and being exposed to this uranium like most of the people in the plant were.

Well, that was in November when I signed up, in 2001, and this is -- this is the feeling of the claimants that happened and this is what's happened to these -- these elderly ladies where their husbands

have died, same thing. They went in and somebody would tell them about it, they signed up.

That spring, the following spring, it was written in the paper that it was reported from -- I believe the Department of Labor -- that the claimants that signed up would be getting their awards in two to three months. Now you've got to remember, these women are in their seventies. I'm in my 70, and they look forward to this. Their husband's obviously gone. Bethlehem Steel is broke, they don't have no health insurance, they have nothing. So they look forward to this.

And lo and behold, ten months later we get notices that we got a dose reconstruction coming. Well, what happened? It's all we -- when we signed up, the people told us it's all you got to do is have cancer and work there at that time, and nobody said -- in my case, bladder cancer wasn't -- wouldn't get paid, that that wasn't one of the cancers. We were led to believe that we were going to get paid. I

thought we'd get paid.

I wish I had known. I wish that man would have told me the day I went to sign that you're not going to get paid because you've got bladder cancer and the dose reconstruction isn't going to let you through, because truthfully, I would have got up and walked home and I would have been happy for the last three years. I wouldn't have -- I would have just -- when I do die, I'd have died happy. I didn't have to go through this thing. And there's a lot of women in the same case.

Well, when we come up with this dose reconstruction, we get this questionnaire. This is no problem. You know, I get cancer and -- we get cancer, and they give me this questionnaire. I look at it. I can't answer a question on there. What badge did you wear, what kind of accidents went on? I haven't got a clue. I didn't even know I was working with uranium, how do I know what's going on?

So the last three or four pages on there asked some questions that I could

answer. But one of the important questions was when we're talking about coworkers is they asked if you had any coworkers, and obviously the other fella that had cancer, and I know a couple of guys that didn't have cancer that weren't claimants, so I put their names down. And I says I got like four witnesses that I worked there, there's no problem with it. So I wrote the names down.

They never checked the coworkers. I called them up later when I was going to have my hearing. I called them up and I said did anybody ever check about where we were and what type of work we done? Hadn't heard a word. So I'm -- and this has happened to a lot of other people. I say what's the sense of asking me for coworkers that can prove what I done and where I worked if you're not going to listen to them? Why even do the questionnaire? As it was, the dose reconstruction comes up and I don't stand a chance. Nothing that I said made any difference at all on whether I get paid or not.

So -- now you got to put yourself in -- you're a 70, 80-year-old lady. She -- she may have -- her husband is gone. She don't know what he done in the plant. She can't find the coworker. She can't answer any questions. We get many calls -- our group gets many calls, what can I do, Mr. Walker, I don't know anybody, nobody's alive that worked with my husband. This questionnaire thing is -- and this dose reconstruction, to me, is a joke. You might as well not send it out. Just send me a letter and say Ed, we're not going to pay you. Simple as that. We figured that you didn't take enough inhalation that you should be getting paid for this cancer thing, and -- and leave me alone. It's fine, I can -- I can accept that. But when -- when you get people like one lady at this meeting we had on the 4th, and I know Larry was there and Jim was there, stood up and they called this lady and told her -- got her check account number because they were going to deposit the money in her account -- and I talked to this lady since then, I found out who it was -- and

two weeks later, nothing happened. Three weeks later they send her a notice that they changed their mind, she's not getting the money. That woman is living on $300 a month pension. She has no insurance. She had to move in with her daughter, and she was promised that. Now there's something -- to me, there's something wrong with this program.

And then I find out that on the site profile you used the air samples from Simonds Saw. How about Bethlehem Steel? How about talking to the people that worked there? How about going into the plant and seeing where -- where this work was done and talk to the people, what they went through? If -- if they had uranium there, you can bet -- and I've got quite a few guys that -- that have worked there at that time that'll go through and verify this, and nobody seems to care. Nobody called on the site profile. I talked to I don't know how many guys, guys that aren't even in my group, just that I know that worked at the plant at that time, did anybody ever contact you about going to

the plant or talk to you about what kind of work you done or how you could have been exposed? Nothing was ever done.

So my question is -- I just -- I feel the program is really bogus. I know you worked hard and you've -- people got the knowledge, the technology and everything, but if you're not going to go around and find out what actually happened and what happened to these people and treat people like that, it isn't even so much -- it's the way the people -- the human side of the thing. How can you do that to -- to your mothers, your grandmothers? I don't understand it.

(Applause)

**MR. WALKER:** That's all I got, though, to say for now. Thank you.

**DR. ZIEMER:** Thank you very much. I don't know, Ed, if you were here earlier today when we had a discussion on those -- those forms, those survey forms, but we've had some concern about how they were viewed and the concerns that they raised with some of the folks. We're trying to address that

because the -- the form is to try to elicit any information that -- that we don't know about. The staff has the site profiles and other information, and they're trying to find out if there's other things, but it may -- it -- it appears at the other end that the expectation is that you have to provide all the information, and that can be very difficult for some of the folks --

**MR. WALKER:** Well, the forms, to an 80-year-old woman --

**DR. ZIEMER:** That's my -- exactly our point, yeah.

**MR. WALKER:** You may just as well print it in Chinese, really. And for me, too. I mean it didn't mean nothing. I -- when you can't fill the thing out, and I went to high school --

**DR. ZIEMER:** We appreciate knowing that --

**MR. WALKER:** -- didn't go to college, but --

**DR. ZIEMER:** -- and we have that same concern and --

**MR. WALKER:** -- when I get a form that

--

**DR. ZIEMER:** -- (Inaudible) figure out how to make those more user-friendly some way.

**MR. WALKER:** Yeah, it's just why send it out?

**DR. ZIEMER:** Yeah.

**MR. WALKER:** Why put the people -- why put these old women through that -- and me, the young man.

**DR. ZIEMER:** Yeah. Thank you.

**MR. WALKER:** Thank you.

**DR. ZIEMER:** Yes, another comment over here, and then -- yeah.

**MR. O'BRIEN:** I said we all admit about the mistakes that have been made. Right? This didn't happen -- and I'll come right out and say that Bethlehem Steel, they lied about it. They put everybody on the wrong track. Otherwise they would have went through there and it would have been a different thing. But there's people today that are still in danger. But now I understand -- we were supposed to have a walk-through. We were going to get together

and have a walk-through with some of your people and some of this committee here. Well, what is it going to accomplish if we can't go to the Labor Department, and who is going to enforce something? I mean I want to know what's the sense of -- the place is still there. Nobody went through it, but Bethlehem Steel said they ripped it down. But the Labor Department -- there's people working there now. They sold it to another company. They're not using it, but they're using it for storage. But men are going in there and they're getting stuff out, running cranes, and they're -- they're all around that stuff. But nobody has checked into it -- I may be wrong, but nobody has checked it. Who do we go to? I don't know. Can you -- anybody tell me? I guess not.

**DR. ZIEMER:** I understand that -- I was asking Larry about the walk-through. I understand that the local folks have invited some of the NIOSH staff to come and see the facility. The enforcement of current health standards -- whose --

**MR. ELLIOTT:** That's the Department of

Labor Occupational Health and Safety Administration, OSHA.

**UNIDENTIFIED:** (Off microphone) That's an agency within the Department of Labor that does --

**DR. ZIEMER:** So if there are current health issues --

**MR. O'BRIEN:** Can anybody here notify them or make -- nobody?

**UNIDENTIFIED:** (Off microphone) You want us to? I mean (Inaudible) --

**MR. ELLIOTT:** The work force who's there currently can exercise their right to approach OSHA. They could also exercise a request --

**MR. O'BRIEN:** I called -- I called my nephew. I asked him, do you go in the old ten-inch mill, are you using it at all? He said yes. I said do you know there could be a possibility of uranium dust over there on the -- on the beams, on the cranes, and do you know that? No, I didn't know it. Well, I told him, but you know how it is with workers and management. I know a fella that told me in one of my investigations on this

they shut off all the cleaners on the newer mills. They have the scrubbers. He was given orders by the main office to shut the scrubbers off at night 'cause then people wouldn't see the junk that was blowing out. In the daytime, shut them -- put them back on again.

**DR. ZIEMER:** Well, it sounds like there's some current concerns that perhaps have to be raised by the local folks. Mike, you wanted to add something to this discussion. Mike Gibson from...

**MR. GIBSON:** This is an Advisory Board meeting on Radiation and Worker Health, but it's going on the record, it's going to be in the *Federal Register*, the transcripts. Are you telling me there's not a Federal agent in this room that could get ahold of OSHA to tour the plant this gentleman's talking about?

**DR. ZIEMER:** I assume there is.

**MR. ELLIOTT:** Well, I'm sure that Roberta Mosier can pass that along to OSHA. But I would also -- I was ready to offer to the gentleman that another way to approach

this is through a health hazard evaluation request where if -- and this can be done anonymously -- if three or more or an organized -- representative of the organized group at Bethlehem Steel simply made a request to NIOSH to come and evaluate the situation and -- and do sampling and whatever else is necessary to make a determination if -- as to whether uranium contamination exists today in the -- in the mill. So there's two mechanisms, and I'm sure that -- you know, I have confidence in Roberta that she'll take this back and within DOL they'll put it in front of OSHA. And any worker who wants to talk to me about how to initiate a request, I'd be happy to walk them through the process.

**MR. KOCHANSKI:** Thank you. The same should go for Carborundum in Niagara Falls. There are 300 or 400 workers at the same buildings that this radiation was processed in. Thank you very much. And one question, how do I get a copy of the minutes of this meeting today? How do I do it?

**DR. ZIEMER:** There's two -- two ways.

You can request them -- we have a request book -- and they will also be on the web site --

**MR. KOCHANSKI:** Thank you.

**DR. ZIEMER:** -- as soon as they're ready, so you're welcome --

**MR. KOCHANSKI:** I can't afford a computer. You saw to it.

**DR. ZIEMER:** I'm not sure any of us can, but you can -- you can get a written copy. There he goes. Sir?

**MR. WALKER:** I don't want to take up much more time, there's other people got questions, but the one -- another thing that bothers this group is that it was -- it was published in the Buffalo News that there was four government sites down south that had a special cohort and just simply having cancer and working there, there was no questions asked, they got paid. Now --

**UNIDENTIFIED:** (Off microphone) (Inaudible)

**MR. WALKER:** Was it at Oak Ridge? I don't know all -- all the sites, but if that special cohort -- it's all you had to do was

prove you had cancer and worked there, now it's being modified for us and it's altogether different than what they had, why did the government sites receive it; when they got up to Bethlehem Steel, the rules changed?

**DR. ZIEMER:** This is a legislative issue that is imposed on all of us here. You need to be speaking to your Congresspeople --

**MR. WALKER:** And we have.

**DR. ZIEMER:** Yeah. I mean the law is -- we're following the way that our Congressmen wrote the law, and they had some of those groups --

**MR. WALKER:** But it's very troublesome to these people.

**DR. ZIEMER:** We understand that.

**MR. WALKER:** They hear that, where they got it.

**DR. ZIEMER:** Right. There's a -- there's a --

**MR. WALKER:** And there's no -- bladder didn't make it, this didn't make it --

**DR. ZIEMER:** No --

**MR. WALKER:** -- you got it, across the board. It even stated in the paper, even if you smoked cigarettes, you got it.

**DR. ZIEMER:** We understand the issue.

**MR. WALKER:** Okay.

**DR. ZIEMER:** Sir?

**MR. ESPINOSA:** Good evening. My name is Kevin Espinosa, spelled the same way as Mr. Espinosa on the Board. I just had one question for Dr. Neton, hopefully you can answer my question. I believe earlier tonight in your presentation you said that you assumed that 20 percent had settled onto the food that was eaten, 20 percent per cubic meter. Could you clarify what you were saying on that?

**DR. NETON:** If I gave that impression, that's not what I meant to say. I said that 20 -- 20 percent could be used -- after you look through the whole model, the calculational method that we used, the mathematics worked out such that we could assume that 20 percent was -- what was in the air per cubic meter ended up being contamination being eaten by touching a

surface or by ingesting food or coffee that was in the area. Now that's not -- that's the way the math worked out, but there's a -- there's a long derivation on our web site that you can look up that describes how -- how we got to that -- that ultimate result. I don't know if that answers your question or --

**MR. ESPINOSA:** It does. I should also -- is there any idea of how long it took for these particles to settle out? I mean we're saying that it settled in one day and was vacuumed up -- it was vacuumed up actually immediately after it was -- after the contamination fell to the ground. I don't think it fell in an hour. I mean I think it took a couple of days to fall on these guys who were working there during the week Monday through Friday.

**DR. ZIEMER:** Well, you can give your criteria --

**DR. NETON:** If you look at the web site, again, I think it's .00075 meters per second is the settling velocity of uranium in air, but it's continuously settling, so

once it's dispersed in the air, it settles continuously throughout a 24-hour period is what we assumed.

**MR. ESPINOSA:** And when was it vacuumed up, then?

**DR. NETON:** No, it doesn't matter whether it was vac-- we assumed it never was vacuumed up for this calculation. It just settled during the whole operation of those derbies, and then when the operation was done, we assumed that there was cleanup done after that. But during the op-- during the 24-hour period we assumed constant generation of up to a 50-milligram per cubic meter air cloud, and that 50-milligram per cubic meter air cloud settled out of the air and deposited on the surfaces over 24 hours.

**MR. ESPINOSA:** (Off microphone) And the particles that were on the beams that settled down the next couple of days (Inaudible)?

**DR. NETON:** Well, that's another issue that was raised by this gentleman, and that was actually part of the motivation for us to go and do the tour of the facility, to

look at the logistics of where things were in relation to the bar mill, to see the height and everything, to see if our exposure model actually addressed settling of contamination up on the beams. So we were going there primarily from a perspective of validating our exposure model rather than looking for additional contamination.

**MR. ESPINOSA:** Thank you very much. It's nice to get some answers.

**DR. ZIEMER:** Thank you. Another comment? Yes.

**MS. BARTOSYEK:** Hi, I'm Janice Bartosyek. I'm with the Bethlehem Steel Action Group. I have a few questions that I'd like to ask of you. First of all, I'd like to make a statement.

I agree with Ed that the way the program was presented to us initially in 2000 -- 2000 or 2001, it was I think blatant government misrepresentation. I mean he's correct when he said if a person had cancer, basically they -- and worked at Bethlehem Steel in the mill, they would be compensated

for what happened. And it never was presented to us in a way that it had to be proved through all of these other methods that the cancer was caused by exposure to radiation.

Now I want to thank Larry for the packet of information that I received from the -- after the last meeting, and I read everything within it. And there was a map of -- in the Bethlehem Steel profile there was a map that was included in it. I'm not sure who's best familiar with the Bethlehem Steel records or profile. I'm looking at this gentleman, presuming that he's maybe the best qualified.

**MR. ELLIOTT:** Unfortunately, Grady Calhoun was the --

**MS. BARTOSYEK:** Okay, well --

**MR. ELLIOTT:** -- most knowledgeable about that and he's --

**MS. BARTOSYEK:** Well, on this map --

**MR. ELLIOTT:** -- left for the day.

**MS. BARTOSYEK:** -- there was a -- okay, it was a -- it was Lackawanna, New York and all of the buildings of Bethlehem Steel.

There was this certain area that was right next to the lake that was circled on this map, and I don't get it. I don't know why -- ah, thank you. I don't know if the circle is representative of the bar mill ten, supposedly. I mean it's not, but does anyone know what this represents, the circled area?

**MR. ELLIOTT:** No, why don't you -- if you would, Janice, would you -- would you either -- we'll send you an e-mail about that. We'll try to provide some clarification. I don't have an answer for you tonight. I don't know --

**MS. BARTOSYEK:** Okay, 'cause I was just --

**MR. ELLIOTT:** -- I'd have to look into this.

**MS. BARTOSYEK:** -- wondering if this is the area or the mill that supposedly they presume was torn down or --

**UNIDENTIFIED:** (Off microphone) No.

**MS. BARTOSYEK:** Oh, no? Something else? A different issue? Okay.

**MR. ELLIOTT:** Let me follow up on that

and I'll get back to you. Okay?

**MS. BARTOSYEK:** Okay. Now in 2000 or 2001 there was a list on the -- of beryllium vendors on the internet site for -- I think it was DOL. And now that has been pulled off. And at one time Bethlehem Steel was listed as a beryllium vendor, and later on it was said that they never were a beryllium vendor. Can somebody make a comment about that?

**MR. ELLIOTT:** I have no idea what you're talking about there. There was -- there was -- I think you're referring to the residual study contamination report, but it included beryllium vendors as well as radiation-exposed AWEs, and there was an error that was inadvertently made in the Bethlehem Steel determination. We talked about this back last month.

**MS. BARTOSYEK:** Uh-huh.

**MR. ELLIOTT:** And the documentation that we have indicates that there was a full cleanup done so that there was not significant residual contamination. That's based upon our document review. We're

anxious and interested in making a site visit if we can and looking at it from that perspective. But I'm not clear on where your information is coming from that this was a beryllium vendor site and then it wasn't. I don't know -- I have no idea what you're talking about there.

**MS. BARTOSYEK:** Well, because it was on one of your -- the government internet sites as -- and Bethlehem Steel was listed as a beryllium vendor. And I happened to get -- print out that information and I've reviewed it numerous times, so I don't feel that I misinterpreted what I printed off the internet at that time. And I pursued the beryllium/silicosis type of thing because at that time my dad -- he did not have any identified cancer problems so I presumed that maybe he had a emphysema and, you know, whatever, other -- other type of problems. And the government at that time mentioned to me that Bethlehem Steel was not a beryllium vendor.

Now the other question I have is what is the total number of pages retrieved of

government records on Bethlehem Steel?

**MR. ELLIOTT:** Here again, I don't know that -- answer to that question specifically.

**DR. ZIEMER:** You can probably get the information.

**MR. ELLIOTT:** I can get that and have it -- you know, have it delivered to you.

**MS. BARTOSYEK:** Okay. In reviewing the information you had sent to me, I compared it with the information I had gotten off of one of your internet sites before the last meeting and looked at all of the rollings, the dates of the rollings, and I noticed on the information you sent me there were five that were not listed previously on NIOSH's site profile for Bethlehem Steel. And I wonder if it has since been added? That information was extrapolated from what you sent to me and I compared it to the list to see if it was already on that list, and I saw that these -- well, they were the experimental rollings, but they were not on that list from -- I don't know, April or May, that was on your internet database.

**MR. ELLIOTT:** Dr. Neton --

**MS. BARTOSYEK:** Does that --

**DR. NETON:** I'm not sure --

**DR. ZIEMER:** If we don't know the answer to that, again, we can ask the staff to follow-up and get that information.

**MS. BARTOSYEK:** Okay. I'm sorry I didn't bring that information with me. I had done a comparison and I could have easily shown it to you but I left it behind.

**DR. ZIEMER:** Thank you.

**MS. BARTOSYEK:** Okay. Thank you.

**DR. ZIEMER:** Thank you very much. We have another individual signed up or requesting --

**MS. OWENS:** (Off microphone) (Inaudible) use the mike. (Inaudible) thirsty for Manhattans by now.

(On microphone) I just wanted to say just one thing of talking. My husband died of cancer in 1998, which started in his kidneys and metastasized to his brain, bone and lungs. He was a wonderful man and a proud -- proud, patriotic American. He served in the United States Air Force for

many years and spent time in World War II, the Korean Conflict, the Berlin Airlift and Viet Nam. Although the risks were phenomenal in all of these military missions, he fortunately survived them all, only to fall victim to what I strongly believe was disease caused by the radioactive contamination he was exposed to in the production of these weapons of war.

One thing else here I wanted to -- I think I did say he started to work at Hooker in early 1950. Now according to the Department of Energy, they had assigned 1948 as the last year that they were willing to compensate the victims at Hooker Electrochemical. The Department of Energy's position is that their contractual relationship with Hooker to produce these lethal materials ended in 1948; therefore they are not responsible for any damages to employees after that in time. However, if the contamination is so extremely difficult, or even impossible to remove completely, how can -- and by no means be accomplished swiftly, how can they be absolved of

responsibility simply because the actual production had ceased? And if not the Department of Energy, should not some governmental entity be accountable for the damage inflicted on these innocent Americans?

**DR. ZIEMER:** Okay. Thank you and --

**MS. OWENS:** Thank you.

**DR. ZIEMER:** -- the gentleman has another comment here.

**REV. LIVINGSTON:** (Off microphone) This is the question that I --

**DR. ZIEMER:** This is --

**REV. LIVINGSTON:** -- for maybe --

**DR. ZIEMER:** -- Reverend Livingston.

**REV. LIVINGSTON:** -- Dr. Neton and the rest of the panel. From what I -- the information that I can gather, that the scientists who work in this field is such a small gene pool, don't -- isn't it a fact that the people who work at Oak Ridge also work for NOSHA (sic) and vice versa? So isn't it a case of the people who are doing the research -- isn't it government checking government? Don't we have such a small gene

pool of the people who are doing the work that they -- I mean half the people who work for Oak Ridge used to work for NOSHA (sic). Either they work for NOSHA or they work for Oak Ridge. How can we get a true accounting of everything that's going on if you have government checking government?

**DR. ZIEMER:** Let me partially answer that. We do have the conflict of interest rules that we follow, which also make known what the previous associations of various folks are because in a sense you're right, there's a somewhat restricted group of individuals who have sort of expertise, some of whom are around this very table today. So the -- about the best we do on this is make known what those associations are and -- and also try to -- try to get honest people who are willing to, in some cases, stick their neck on the line if they have to. The fact that they have worked somewhere previously does not necessarily mean that they can't do their job. It could raise some issues and we're aware of those perception problems and try to minimize them

to the best that we're able, really.

A gentleman here, identify yourself, please?

**MR. LAWRENCE:** Just a quick follow-up. I'm not signed in but my name is David Lawrence. I'm from West Seneca, New York. And I don't know if you're going to have anything further -- as I was standing here you -- you addressed it. It gets into the potential conflict of interest issue, and you may have covered this today in your day meetings. I was not here.

I assume there will be a firm hired to participate in work on the audit -- auditing the --

**DR. ZIEMER:** Yes, that firm has already been hired and identified and --

**MR. LAWRENCE:** And that firm is?

**DR. ZIEMER:** SC&A Associates, and they will be participating in the meeting tomorrow, giving a report to the Board tomorrow.

**MR. LAWRENCE:** And what would -- how would you characterize the status of potential conflicts of interest? Have they

or do they receive contracts from Federal government agencies, the firm hired to do the audit?

**DR. ZIEMER:** Other government agencies? I don't recall what their current -- I'm -- I don't think I know the answer to that at the moment. I think they certainly have in the past.

**MR. LAWRENCE:** I think for the record I want to make that known that that is an issue that we are concerned about.

**DR. ZIEMER:** Right.

**MR. LAWRENCE:** With Oak Ridge and -- please, someone correct me if I'm wrong, but I believe Oak Ridge Associates who prepared the dose reconstruction regularly receives government contracts from various agencies.

**DR. ZIEMER:** Thank you. Other comments? We do have -- I forget the exact wording of the requirement, but SC&A is not permitted, I don't think currently, to have any major DOE contracts. Is that how it's worded? Maybe, Jim, you can help me out. I forget the exact requirement. There are some requirements on that.

**DR. NETON:** SC&A does not have any Department of Energy, nor will they entertain any contractual work with NIOSH on other projects during the five-year performance period of this contract.

**DR. ZIEMER:** Right.

**DR. NETON:** To my knowledge, they do not have any Department of Energy contracts at this time.

**DR. ZIEMER:** They may have had in the past. Are there any other members of the public that wish to make comments this evening?

(No responses)

If not, let me thank all of you for coming. We appreciate your input. We will try to be responsive to it and do our best to make this program successful. Again, we appreciate your time and effort to come out here tonight and we're recessed till tomorrow. All of you are welcome back to our sessions tomorrow morning.

(Whereupon, the meeting adjourned at 8:45 p.m.)

**C E R T I F I C A T E**

STATE OF GEORGIA )
)
COUNTY OF FULTON )

I, STEVEN RAY GREEN, being a Certified Merit Court Reporter in and for the State of Georgia, do hereby certify that the foregoing transcript was reduced to typewriting by me personally or under my direct supervision, and is a true, complete, and correct transcript of the aforesaid proceedings reported by me.

I further certify that I am not related to, employed by, counsel to, or attorney for any parties, attorneys, or counsel involved herein; nor am I financially interested in this matter.

WITNESS MY HAND AND OFFICIAL SEAL this _____ day of June, 2004.

_____

STEVEN RAY GREEN, CVR-CM

GA CCR No. A-2102