

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-SIXTH MEETING

ADVISORY BOARD ON
RADIATION AND WORKER HEALTH

VOL. II

The verbatim transcript of the Meeting of the
Advisory Board on Radiation and Worker Health held at
the Shilo Inn Suites, 780 Lindsay Boulevard, Idaho
Falls, Idaho, on August 25, 2004.

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C O N T E N T S

REGISTRATION AND WELCOME	
Dr. Paul Ziemer, Chair.	
Mr. Larry Elliott, Executive Secretary6
ADMINISTRATIVE HOUSEKEEPING	
Ms. Cori Homer, NIOSH; Dr. Paul Ziemer, Chair;	
Mr. Larry Elliott, Executive Secretary6
USE OF UNCERTAINTY IN DOSE RECONSTRUCTION	
Dr. Jim Neton, NIOSH	23
SCIENTIFIC RESEARCH ISSUES UPDATE	
Mr. Russ Henshaw, NIOSH	51
SUBCOMMITTEE STATUS	
Dr. Paul Ziemer, Chair	65
PUBLIC COMMENT	172
REVIEW AND APPROVAL OF DRAFT MINUTES, MEETING 25	197
BOARD DISCUSSION/WORKING SESSION	
Dr. Paul Ziemer, Chair	205
ADJOURN.	256
COURT REPORTER'S CERTIFICATE.	257

Legend of the transcript:

[sic]	Exactly as said
[phonetic]	Exact spelling unknown
--	Break in speech continuity

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

(By Group, in Alphabetical Order)

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(in order of appearance)

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Mr. Russ Henshaw, NIOSH
Dr. Paul Ziemer, Chair

STAFF/VENDORS

Cori Homer, Committee Management Specialist, NIOSH
Steven Ray Green, Certified Merit Court Reporter

NANCY LEE & ASSOCIATES

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ANDERSON, BETTY A.
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BRAILSFORD, BEATRICE
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BRASWELL, TODD
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PETERSON, HENRY K.
POWELL, STEVE
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SCHAEFFER, D. MICHAEL
SCHAUER, DAVID
TENFORDE, THOMAS S.
TOOHEY, R.E.

NANCY LEE & ASSOCIATES

P R O C E E D I N G S

(8:30 a.m.)

REGISTRATION AND WELCOME

DR. ZIEMER: Good morning, everyone.

We'll reconvene for the second day of this Board meeting.

ADMINISTRATIVE HOUSEKEEPING

We have a number of administrative matters to take care of. I think if Cori is here -- Cori, let's start out with the information on our next meeting and make sure everybody has the time and date and location. You may recall originally we thought we were going to be headed to Washington, D.C., but actually could not find a hotel there, so we went to Plan B. So Cori will tell us about Plan B.

MS. HOMER: Okay.

DR. ZIEMER: Which, for some, was Plan A, actually.

MS. HOMER: Okay. I think some of you are already aware, we'll be meeting in San Francisco in October. There were -- there was no room at the inn, so to speak, in Washington, due to the elections. And we will be staying at the Westin St. Francis. I've reserved three days,

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1 one for the subcommittee meeting and two for the
2 full Board meeting, for the 19th, 20th and 21st.

3 It'll be up to you to decide which of those days
4 will be for the full Board and the subcommittee,
5 as I haven't made final arrangements for that.
6 The contract was just signed last week.

7 DR. ZIEMER: I think the subcommittee
8 will have to go on the day before the Board
9 meeting --

10 MS. HOMER: I believe so.

11 DR. ZIEMER: -- so we'll put that on the
12 19th and then the Board on the 20th and 21st.

13 MS. HOMER: Okay.

14 DR. ZIEMER: Huh? Right?

15 DR. ANDERSON: Yeah. I mean just so you
16 know, the Board of Scientific Counselors for
17 NIOSH meets on the 21st, so I won't be able to be
18 there. I had us down for the -- Monday, Tuesday,
19 Wednesday.

20 DR. ZIEMER: What -- the 19th is a
21 Tuesday?

22 MS. HOMER: It's a Tuesday. I was
23 trying to avoid folks flying on weekends.

24 DR. MELIUS: The 21st is bad for me
25 then, too, if I'm still on. I don't know if my

1 term's up or what's going on.

2 DR. ZIEMER: Are people willing to fly
3 on the 18th if --

4 DR. ANDERSON: Well, the 18th would be
5 the subcommittee.

6 DR. ZIEMER: I mean on the 17th. But we
7 don't know about availability at the hotel at
8 this point. Right?

9 MS. HOMER: I can check and see if we
10 can rearrange those dates, if I can renegotiate
11 the contract.

12 DR. ZIEMER: Do we lose two of you on
13 the 21st? Is that -- but everybody's okay if we
14 went 18, 19, 20? Could you check on that then?

15 MS. HOMER: I'll check into it and get
16 back with you.

17 DR. ZIEMER: Let's see if -- we'll see
18 if we can get that modified.

19 MS. HOMER: Okay.

20 DR. ZIEMER: Thank you very much. Okay,
21 go ahead.

22 MS. HOMER: All right. Now the
23 following meeting -- I'll put Washington, D.C. on
24 the top of the list and see if we can arrange
25 that, but I'll need some dates for the meeting

1 following the October meeting.

2 DR. ZIEMER: We're at mid-October.

3 MS. HOMER: Uh-huh. Do we want to try
4 for late November?

5 DR. ZIEMER: We're probably going to get
6 into December, at the earliest, it's -- I would
7 suspect.

8 MS. HOMER: Okay. Well, there's the
9 1st, 2nd and 3rd of December. December 1st, 2nd
10 and 3rd?

11 DR. ZIEMER: Well, let's -- let's check
12 the December dates. I'm out of the loop 1st, 2nd
13 and 3rd.

14 MS. HOMER: Okay.

15 DR. ZIEMER: How about the week of the
16 6th? Out all week?

17 MS. HOMER: Gen is out?

18 DR. ROESSLER: (Off microphone) Well,
19 until the 9th.

20 DR. ZIEMER: Again, we're now looking
21 for -- well, we can still go two days, depending
22 on who's on the subcommittee.

23 MS. HOMER: Uh-huh.

24 DR. ZIEMER: Right.

25 DR. DEHART: The week of the 13th?

1 DR. ZIEMER: 9th and 10th are out? 9th
2 and 10th are okay?

3 DR. DEHART: The 10th isn't for me.

4 DR. ZIEMER: The 10th is not. Okay.
5 Let's kind of keep track of -- the 10th we would
6 lose one person?

7 DR. MELIUS: Lose two.

8 DR. ZIEMER: Lose two, okay. Let's look
9 at third week, 13th -- week of the 13th. Let me
10 just go through the --

11 MR. ESPINOSA: (Off microphone) I'm out
12 on the 17th.

13 DR. ZIEMER: Okay, Rich is out on the
14 17th.

15 MR. ESPINOSA: (Off microphone) Actually
16 16th and 17th.

17 DR. ZIEMER: Sixteen and 17 out -- 13,
18 14, 15?

19 MS. HOMER: Looks good?

20 DR. ZIEMER: Thirteen, 14, 15?

21 MS. HOMER: Okay. How about an
22 alternate? Is that --

23 DR. ZIEMER: Tentative, December 13, 14,
24 15 in D.C. Let's look at a fall-back...

25 MS. HOMER: Yeah, alternate location.

1 DR. ZIEMER: I'm going to assume the
2 week of the 20th is probably not very good.

3 MS. HOMER: Huh-uh.

4 MS. MUNN: That's a good assumption.

5 DR. MELIUS: But nobody has meetings on
6 the 24th and 25th, so they're free.

7 DR. ZIEMER: The week of the 27th? A
8 sufficient number of groans that -- okay, now
9 we're into January. Week of --

10 MS. HOMER: The 3rd?

11 DR. ZIEMER: Week of January what?

12 MS. HOMER: January 3rd?

13 DR. ZIEMER: Week of January 3rd.

14 DR. ANDERSON: I have a conflict on the
15 5th.

16 DR. ZIEMER: I do, too -- 6th or 7th?

17 DR. ANDERSON: 6th I do.

18 DR. ZIEMER: Conflict?

19 DR. ANDERSON: Yeah, 5th and 6th.

20 MR. ESPINOSA: We're talking about D.C.
21 on this. Right?

22 DR. ANDERSON: Yeah.

23 DR. ZIEMER: Let me check again.

24 January 3rd and 4th? 5th? 3rd, 4th and 5th?

25 DR. ANDERSON: I've had -- the 5th is a

1 problem.

2 DR. ZIEMER: 5th is a --

3 DR. ANDERSON: 5th and 6th.

4 DR. ZIEMER: Actually I have a conflict
5 on the 5th, also.

6 Week of the 10th.

7 MR. ELLIOTT: 10th, 11th and 12th is not
8 good.

9 UNIDENTIFIED: (Inaudible)

10 DR. ZIEMER: In where?

11 MR. ELLIOTT: She's saying in January
12 before the inauguration --

13 DR. ZIEMER: Oh, before the
14 inauguration.

15 MS. HOMER: The week of the 17th? Is
16 that okay -- 24th?

17 UNIDENTIFIED: 24th is fine.

18 MR. ESPINOSA: Are we stuck to D.C.?

19 DR. ZIEMER: 24?

20 MR. ESPINOSA: Can we --

21 DR. MELIUS: I've got a conflict the
22 week of the 24th.

23 MR. ESPINOSA: Can we select an
24 alternate location, too?

25 MR. PRESLEY: That's what I was going to

1 say, if we couldn't -- if we can't make D.C. the
2 13th, 14th and 15th, can we select an alternate
3 location, go to Cincinnati that week or
4 something?

5 MS. HOMER: Well, would you consider
6 something a little more southern, because it's
7 winter? It might make it a little easier for
8 travel.

9 DR. ZIEMER: That probably will work
10 better to have an alternate location rather than
11 an alternate date, it appears. Otherwise you're
12 going to get into February and it's too long.

13 MR. PRESLEY: That's too long.

14 DR. ZIEMER: Okay.

15 MS. HOMER: Amarillo has come up.

16 DR. ZIEMER: Amarillo, Pantex.

17 MR. PRESLEY: Amarillo --

18 MS. HOMER: And Savannah is a
19 possibility.

20 MR. PRESLEY: Amarillo, the weather's as
21 bad there as it is --

22 DR. ZIEMER: Yeah.

23 MS. MUNN: Savannah's nice.

24 DR. ZIEMER: Savannah is not really near
25 the Savannah River Site. It's a nice place, but

1 if you want to go near the Savannah River Site,
2 you almost have to go to Aiken.

3 MS. HOMER: Or Augusta.

4 DR. ZIEMER: Or Augusta.

5 DR. ANDERSON: We did that.

6 MS. HOMER: How close is Amarillo to the
7 Pantex plant?

8 DR. ZIEMER: Well, that's the -- that's
9 the town.

10 MS. HOMER: Is it? Okay. Would you
11 like --

12 DR. ZIEMER: It's in the panhandle of
13 Texas. It's not southern weather.

14 MS. HOMER: Well, we could consider New
15 Mexico again. We could do --

16 MR. ESPINOSA: I second.

17 DR. DEHART: There is the bonus* reactor
18 plant in Puerto Rico.

19 MS. HOMER: Oh, I'm all for Puerto Rico.

20 DR. MELIUS: There's also Amchitka.

21 DR. ZIEMER: I don't think you're going
22 to have many claimants from Puerto Rico. If we
23 go to Amarillo, I'm not sure you're going to get
24 a tour of the Pantex plant. It's probably
25 unlikely, but you might get some -- how many

1 claims do we have from Pantex? Do we -- there's
2 a worker group there that we could interact with.

3 That would be the main reason for going to
4 Amarillo would be to interact with the worker
5 groups there. But I think we could find a better
6 time of year for Amarillo, frankly --

7 MS. HOMER: Think so?

8 DR. ZIEMER: -- if -- it can be pretty
9 harsh.

10 MS. HOMER: Well, there was a list
11 originally developed from some suggestions from
12 Board members of locations to go. We've been to
13 almost all of them. Nashville is still on the
14 list, Albuquerque we haven't been -- we've been
15 into the area, but not specifically.

16 DR. ZIEMER: Why was Nashville on the
17 list?

18 MS. HOMER: I'm not sure.

19 MR. PRESLEY: There's two places close
20 to Nashville. You've got Clarksville. I don't
21 know how many claims we've got from up there, but
22 that's close to Paducah and Clarksville.

23 DR. ZIEMER: What's the closest large
24 city to Paducah?

25 MR. PRESLEY: St. Louis.

1 MR. ELLIOTT: Evansville.

2 DR. ZIEMER: You can't get to Evansville
3 from anywhere. Dick?

4 DR. TOOHEY: (Off microphone)
5 (Inaudible) considered Tampa for the (Inaudible)
6 plant down there?

7 MS. HOMER: Do we have work down there?

8 DR. ZIEMER: Pinellas had almost no
9 radioactivity in their site. They did timers and
10 things. Did --

11 MR. ELLIOTT: Tritium is it.

12 DR. ZIEMER: Yes, they did have tritium.

13 Do you have claimants from Pinellas?

14 MR. ELLIOTT: Yes, we do.

15 MR. PRESLEY: We do have claimants?

16 MS. HOMER: Oh, a Tampa area --

17 DR. ZIEMER: Well, then that would be a
18 good --

19 MS. HOMER: Okay, I'll put Tampa as an
20 alternate.

21 DR. ZIEMER: Yeah.

22 MS. HOMER: You'll be okay with Tampa?
23 Okay. I'll bet I can get hotel space real cheap
24 right now.

25 DR. ANDERSON: Do we want to pick a

1 February date?

2 DR. ZIEMER: Actually, for worker
3 outreach, Tampa might be a better selection
4 anyway than D.C. --

5 MS. HOMER: Would you like me to put
6 that on top of the list?

7 DR. ZIEMER: -- wouldn't it?

8 MR. ELLIOTT: It's your choice. I just
9 want to know -- I want to -- I'm lost here. Are
10 we talking about December?

11 MR. PRESLEY: December.

12 DR. ZIEMER: December.

13 MS. HOMER: Okay. So you want Tampa on
14 top of the list as opposed --

15 DR. ZIEMER: How many prefer Tampa for
16 the December meeting? How many prefer D.C.?
17 Five. I actually prefer D.C. Okay, I think
18 we're going to stay with D.C. for --

19 MS. HOMER: Okay.

20 DR. ZIEMER: -- and Tampa's Plan B.

21 MS. HOMER: Okay. Do we want to
22 schedule a February meeting?

23 DR. ZIEMER: Let's -- let's find some
24 dates for February, we'll finish that up. First
25 week of February, week of February 1st? Bad

1 days?

2 DR. ANDERSON: Tuesday. I could change
3 it -- a dentist appointment.

4 DR. ZIEMER: Oh, that doesn't count.
5 Any conflicts the first week of February?

6 MS. MUNN: Are you talking about 1, 2,
7 3, 4 or the 7th?

8 MS. HOMER: 1, 2, 3, 4.

9 DR. ZIEMER: That was 1, 2, 3, 4. How
10 about the week of the 7th? Any conflicts week of
11 the 7th?

12 DR. MELIUS: The latter part of that
13 week is bad for me.

14 DR. ZIEMER: But 7, 8, 9 is okay?

15 DR. MELIUS: 7, 8, 9's okay.

16 DR. ZIEMER: Is 10 not good?

17 DR. MELIUS: 10 and 11 are bad.

18 DR. ZIEMER: Okay.

19 MS. MUNN: 1, 2, 3, 4 is okay?

20 DR. MELIUS: 1, 2, 3, 4 is okay, too.

21 MS. HOMER: Okay.

22 DR. ZIEMER: 1, 2, 3, 4 is -- February,
23 first week of February?

24 DR. MELIUS: Tampa?

25 MS. HOMER: Yeah, I'll use the primary

1 and the alternate location selections you've
2 made.

3 DR. ZIEMER: Incidentally --

4 MS. HOMER: One'll be --

5 DR. ZIEMER: Incidentally, that first
6 week of February would include January 31st. I
7 think that's one day of that week. Any conflicts
8 on the 31st, so that's included as the... Okay,
9 we'll see what's available --

10 MS. HOMER: Uh-huh.

11 DR. ZIEMER: -- that week. Maybe --
12 which -- depending on whether D.C. or Tampa works
13 out, then we can use the other one for the --

14 MS. HOMER: That's correct.

15 DR. ZIEMER: Okay, very good. Thank
16 you.

17 MS. HOMER: Okay.

18 DR. ANDERSON: So which -- which days?
19 The start of the first of the week?

20 DR. ZIEMER: She's got to check on hotel
21 availability. That will influence it.

22 DR. MELIUS: Cori, could I ask you --
23 that when we switch locations like we did for the
24 next meeting or as soon as you pin down the
25 dates, let us know --

1 MS. HOMER: I'll let you know.

2 DR. MELIUS: -- 'cause I heard by rumor
3 and I -- it really disrupted --

4 MS. HOMER: It wasn't too much before
5 you asked me, actually --

6 DR. MELIUS: No, I know, I know, but --

7 MS. HOMER: -- that I had booked it, so
8 --

9 DR. MELIUS: I underst-- but I'm just
10 saying in -- also if we keep a whole week open,
11 then calendars fill up and --

12 MS. HOMER: Okay.

13 DR. MELIUS: -- as soon as we can pin
14 down the actual dates, it's helpful.

15 MS. HOMER: Okay.

16 DR. ZIEMER: Okay, thank you. Cori has
17 some additional --

18 MS. HOMER: I do.

19 DR. ZIEMER: -- things for us.

20 DR. MELIUS: And I will speak to the
21 Chair of the Board of Scientific Counselors for
22 NIOSH about his scheduling, also -- not letting
23 us know about meetings.

24 MS. HOMER: To move on to other issues,
25 for those of you that still have vouchers

1 outstanding, if you have not sent me voucher
2 information this year or I'm waiting on signed
3 vouchers, you need to forward those to me as soon
4 as possible. We have fiscal year closeout, and
5 it's a little earlier than usual this year. So
6 if I haven't received any information from you by
7 early September, I'm going to close out your
8 voucher based on what information I have
9 available.

10 In the future, travel orders and
11 vouchers are going to be forwarded to you via e-
12 mail. It's something that's been available for a
13 while and I think some of you have sent that
14 information when we're short of time. But it
15 seems to be so much easier than Federal
16 Expressing the materials to you. And I think all
17 of you have the expense sheets by e-mail. If you
18 don't, I'll be more than happy to send those to
19 you.

20 I will keep a stock of return envelopes
21 on hand, so just see me if you need them so that
22 you can mail your vouchers back to me without
23 having to pay for your postage.

24 Also, because we are --

25 MR. ELLIOTT: I need to reinforce that.

1 If you don't get your vouchers in, we're going
2 to be pestering you.

3 MS. HOMER: Oh, yeah.

4 MR. ELLIOTT: Because I can't let Cori
5 just finish them out without -- with whatever
6 information she has. We will be pestering you.
7 We do have to close out by the end of this fiscal
8 year, and they've upped the time for closeout --
9 instead of first of September -- right? It's --

10 MS. HOMER: I think it's the first of
11 September.

12 MR. ELLIOTT: First of September now is
13 the cutoff, so we have to get this done by the
14 first of September.

15 MS. HOMER: Uh-huh. Because, again, of
16 the short time frame for fiscal year closeout, I
17 need to get your time as soon as possible. So
18 we're going to go back to the old system we used
19 to use; just write down your time, broken out by
20 preparation -- subcommittee, for those that
21 served on the subcommittee, preparation; and work
22 group for those that served on the work group, so
23 Larry can sign off on that and give it to me
24 today and I'll be able to submit it on Monday
25 when I'm back in the office, make sure that y'all

1 get paid.

2 Now for tour attendees for the tour of
3 the Idaho National Engineering and Environmental
4 Lab tomorrow morning, we need to be ready, in the
5 lobby, by about 7:00, 7:05 a.m. They'll be
6 sending a van by to pick us up. We'll be going
7 to the local facility for a movie -- well, most
8 of you I think have seen the agendas. If you
9 haven't, I have them on file in back. If you ask
10 me for one I'll be more than happy to provide you
11 with it.

12 They have suggested, as usual, casual
13 dress. It will not be a windshield tour. We
14 will be going inside some of the facilities, so
15 dress as comfortably as possible. They have
16 suggested that no one wear anything polyester.
17 They set off the geiger counters.

18 MR. PRESLEY: Radon.

19 MS. HOMER: That's exactly what she told
20 me. You can take your phones with you in the
21 van, but you will not be able to take them in the
22 facilities, so any electronics you have -- it
23 might not be a bad idea just to leave them at the
24 hotel. And they suggested bringing an umbrella
25 because it looks like rain, so -- any questions?

1 (No responses)

2 USE OF UNCERTAINTY IN DOSE RECONSTRUCTION

3 DR. ZIEMER: Okay. Thank you very much.

4 Okay, let's move on to the next agenda item
5 then, which is a presentation by Jim Neton on use
6 of uncertainty in dose reconstruction.

7 (Pause)

8 DR. NETON: Well, good morning. Thank
9 you, Dr. Ziemer. The title of this session is
10 use of uncertainty in dose reconstruction. This
11 is something that the Board had some interest in
12 at the last meeting and so I put together a
13 number of slides to talk about an overview of how
14 we actually assign uncertainty for different
15 applications in the dose reconstructions. In the
16 time I have allotted here I can't go into an
17 extreme amount of depth, but maybe if I whet your
18 appetites for any additional descriptions or
19 whatever, we can address that maybe in future
20 sessions.

21 So just some rudimentaries of what the
22 uncertainty is all about in the dose
23 reconstruction process. As you know, the IREP
24 model itself and the way Congress enacted the
25 statute was that we use the IREP model, which is

1 a Monte Carlo sampling program that applies
2 uncertainty to the distributions for the risk
3 coefficients. And in fact, the front end input
4 to that model is the dose reconstructions, which
5 we also use uncertainty distributions in that
6 calculation. So some of this is probably a
7 review for folks, but I just wanted to set the
8 groundwork.

9 The value for the central tendency of an
10 uncertainty distribution will represent our best
11 estimate. So you know, we do go to some lengths
12 to try to figure out what really is our best
13 estimate of the worker's exposure at the
14 facility, at that job during that time period.
15 But then we can take advantage of the probability
16 distribution functions within IREP to assign some
17 uncertainty about that distribution to encompass
18 the fact that we don't know exactly what
19 happened. I mean I don't think anybody in this
20 audience could say you know anything with any
21 certainty, and the goal here is to address that
22 uncertainty as quantitatively as possible, and
23 when an exact quantitation's not possible, to
24 incorporate claimant-favorable assumptions.
25 That's always our overrid-- our over-arching

1 factor here is if we don't know, science can't
2 inform us, we'll include some favorable
3 assumptions in the uncertainty distributions.

4 The distributions that we employ, and
5 I'll get into this a little later, vary
6 considerably depending upon the application, what
7 we are doing with that dose reconstruction.

8 I think we've all talked about the
9 efficiency process and how we will make some
10 worst-case assumptions at the beginning of dose
11 reconstructions to see if, even under those
12 worst-case considerations, a claimant is non-
13 compensable or likely to be non-compensable; then
14 we'll terminate the dose reconstruction. That's
15 all written in some detail in our regulation, 42
16 CFR part 82.

17 Under those conditions the distribution
18 may be represented by a constant. I mean that is
19 a distribution. The simplest distribution is a
20 single value.

21 Conversely, if we don't have any
22 information available for individual workers, as
23 I discussed yesterday for -- when we use coworker
24 data, we'll develop some model distribution based
25 on the data available to us. If we have 5,000

1 samples, it may be that they best fit a lognormal
2 distribution or normal or triangular or whatever.

3 One thing I do want to point out,
4 though, the uncertainty in the organ dose is one
5 of the many factors involved in the calculation
6 of the excess risk -- excess relative risk.
7 There are a huge number of variables in these
8 calculations. And in fact, it's been our
9 experience that for very uncertain cancer models
10 where the models are not well known, the
11 uncertainty in the dose distribution makes very
12 little difference in the overall probability of
13 causation. You can increase the uncertainty
14 distribution by a factor of two or more, and as
15 long as the central estimate stays the same, your
16 probability of causation won't vary very much at
17 all. That's because the over-arching
18 contribution to the probability of causation, the
19 uncertainty in that probability of causation, is
20 the uncertain cancer model.

21 Early on we thought it would be best
22 maybe to do a sensitivity analysis; to get our
23 best bang for the buck, to go through and look at
24 where we needed to focus on refining these
25 uncertainty distributions where they made the

1 biggest difference. At the end of the day,
2 though, there are so many factors involved that
3 we could not predict with any certainty where --
4 you know, where we should focus our efforts.

5 These are just some of the factors I've
6 outlined that are involved in the uncer-- other
7 sources of uncertainty in probability of
8 causation. Of course the cancer model itself,
9 the risk model, is uncertain. It's based on a
10 finite number of cancers, primarily -- as we know
11 -- from the Hiroshima/Nagasaki atomic bomb
12 survivors. There are not a lot of cancers in
13 those cohorts, and also there are issues of
14 adjusting those cancers to transfer to the U.S.
15 population. Of course the dose rate -- dose and
16 dose rate effectiveness factor has uncertainty
17 about it, as do the radiation effectiveness
18 factors.

19 In fact, I've gone through and looked at
20 this and, for example, a lot of our exposures are
21 due to alpha radiation. And as we discussed at
22 previous meetings, the radiation effectiveness
23 factor in our model varies, unlike the regulatory
24 framework that's used in the workplace where, for
25 instance, one would assign a radiation ef--

1 they'll -- it'll be called a quality factor or
2 radiation weighting factor. Regulatory purposes
3 assign a quality factor of 20, so all doses will
4 be multiplied by 20.

5 In our scheme, the radiation
6 effectiveness factor is allowed to vary somewhere
7 between four and 100, with a best estimate around
8 18. That uncertainty in itself adds a huge
9 amount of overall uncertainty to the model. And
10 in fact -- I'll talk about this a little later --
11 for models like Bethlehem Steel, that is the
12 largest single contributing factor to the overall
13 uncertainty for some cancer estimates. It was
14 over 58 percent of the uncertainty in the PC
15 calculation was due to the radiation
16 effectiveness factors in certain instances.

17 So it's a very complex issue. I guess
18 I'm trying to lay the framework here that there's
19 no simple -- simple discussion on this.

20 Okay. The uncertainty distribu-- there
21 are a large number of uncertainty distributions
22 available to statisticians and those who do model
23 data. These are examples of the ones that we've
24 used in dose reconstructions thus far. I've
25 mentioned that constant. That falls out from the

1 -- you know, the worst-case assumptions that we
2 use, we'll assign a constant and move forward.
3 The log -- the normal distribution, which of
4 course is a bell-shaped curve that we may all be
5 familiar with that has a central tendency and be
6 characterized by the average value and some
7 estimate of standard deviation -- how tightly
8 that data is grouped about this little bell-
9 shaped curve.

10 And the lognormal, which is really sort
11 of a special case of the normal. The data tend
12 to be skewed towards the lower values, and then
13 there'll be a few outliers at the upper tails --
14 not a few, there will be outlier -- I guess I
15 shouldn't call them outliers. There will be
16 values at the upper tails. That typically is a
17 distribution that's observed in many, many
18 workplace environment exposure conditions, and in
19 fact most environmental conditions where you'll
20 have a lot of values that are grouped fairly
21 close, but then you have some processes or
22 parameters that are unknown that just add
23 uncertainty and create these larger values.

24 The triangular distribution, which we've
25 taken advantage of in some of the exposure models

1 -- and I'll talk about that later -- in my mind
2 is really a sort of a claimant-favorable version
3 of the lognormal in the sense that a lognormal
4 distribution has a sort of a bell-shaped curve
5 and then a log tail. With the triangular, you
6 only know -- you only have to specify the
7 minimum, the mode and the maximum value. So you
8 have the smallest value, the most frequently-
9 occurring value, and then the highest value, so
10 you have sort of this triangle, and that triangle
11 can be skewed one way or the other, depending on
12 where you pick that middle value. That could be
13 construed to look like a lognormal, except that
14 you don't have the declining tail, so that you
15 sort of extend the upper -- the distribution of
16 the upper values is extended out further in -- in
17 -- on the X axis. I've got a couple of pictures
18 of this that will maybe help explain it a little
19 better.

20 I just throw this up here because this
21 is -- this is the efficiency process that's
22 included in our implementation guide, and just to
23 point out, you know, why -- how this would work
24 for a constant. As we all know, with the
25 efficiency process we pick the worst-case

1 assumption. For external, say we feel that's the
2 most likely mode of exposure, you add up all the
3 doses based on those worst-case assumptions. If
4 it's a low probability, you do the same for
5 internal, and if it's low, you're done. If by
6 assigning a constant to all these values the
7 person ends up at ten percent, there's no reason
8 to move forward. That's a great idea, and one
9 would argue why not just assign a constant to
10 everybody. Well, the problem is, in some of
11 these calculations a constant is used six or
12 eight times. And as was learned early on in the
13 EPA modeling, if you keep using a constant every
14 step along the way, then you end up with some
15 really improbable value at the end of the day.
16 So that's when we would back off and then use the
17 uncertainty propagation using Monte Carlo
18 techniques.

19 This just sort of defines how we use the
20 constant for a worst-case assumption. This is
21 just a quotation out of the regulation. It
22 essentially says the highest reasonably possible
23 value based on reliable science, documented
24 experience and relevant data. In essence, we're
25 saying we wouldn't use some absurd value. We

1 wouldn't pick a million rem or something like
2 that. We would evaluate the workplace
3 environment and pick the highest value that would
4 make sense, given that exposure scenario.

5 Okay. This gets into a little bit about
6 the -- I'm glad it's early in the morning. I
7 hope everybody's had a little coffee. These are
8 -- the titles are hard to read, but the
9 distributions I think are fairly visible. And I
10 just wanted to point out some examples of some
11 distributions. For example, this would be a
12 normal distribution, a nice bell-shaped curve.
13 This is an example of -- a fairly good example of
14 a triangular distribution where you have a
15 minimum value, the mode -- the most frequently-
16 occurring probability value, then the highest
17 value we could conceive of assigning. This is a
18 nice example of a lognormal. You can see it
19 looks sort of like a normal in this area, but the
20 you have this tail out here where there are
21 straggling values that add to the overall
22 uncertainty, so you've got the three.

23 Now what I wanted to point out, too, I
24 alluded to earlier is why not use a constant at
25 every step along the way. You can do that. For

1 instance, this is -- this is right out of our
2 implementation guide for external dosimetry. If
3 one wants to do a fully-researched dose
4 reconstruction, this is what we would do for an
5 external dose. You would take the dosimeter
6 reading, the value that's on the badge -- and
7 that has some distribution about it; let's say
8 that's plus or minus 20 percent. Now you take
9 the work -- the conversion of the dose -- the
10 measurement on the dosimeter to some value to the
11 tissue -- to the -- the regulatory value, the
12 rem, the radiation equivalent man value. That
13 has an uncertainty distribution about it, and
14 then you end up with the dosimeter dose. But
15 then you have to propagate in -- let's say this
16 person -- this was their actual readings on the
17 dosimeter. Now you have readings that were
18 recorded as zero. They were sensor(censored)*
19 data. There's some missed dose that we have to
20 add in. This in fact would be our estimate of
21 the distribution of missed doses. The most
22 frequently-occurring value here would be the
23 limit of detection divided by two, and the 95th
24 percentile tail out here would be the limit of
25 detection times n, the number of dosimeters, so

1 we would generate this lognormal distribution.
2 Then you have to convert the missed dose again to
3 some value of badge reading to actual dose to the
4 organ, come up with that dose. And then you've
5 got the same situation with the environmental
6 dose.

7 So my point here is you've got six
8 different parameters that overall end up with a
9 propagated uncertainty distribution. If we --
10 and we do this for certain cases. We can take --
11 on a worst-case assumption we will take the
12 highest value of each of these distributions, run
13 them through the probability of causation
14 calculation, demonstrate that the person's PC is
15 less than ten percent, 20 percent. We don't have
16 to go through these iterations, which are very
17 time-consuming. To do each of these runs a
18 couple of thousand times, propagate this run
19 through and then you end up with this
20 distribution, which you have to characterize -- I
21 would say that this pretty much looks like a
22 lognormal distribution, which it probably is; we
23 would analyze it, of course, with some formulas
24 to determine that -- and then that would be the
25 input term for this person's bone marrow dose.

1 So that's how uncertainty distribution is handled
2 within the actual external dose calculation.

3 Now if you get to internal dose, that's
4 a whole different world. I mean those of you who
5 have done anything with internal dose recognize
6 that coming up with an internal dose value has a
7 lot more -- more assumptions involved in the
8 calculation than in the external arena. So what
9 we've done to simplify the calculation is that
10 we've considered all internal doses to be
11 lognormally distributed with a geometric standard
12 deviation of three. I'll explain, in practical
13 terms, what that means in the next slide. This
14 gets us out of the arena of trying to account for
15 the tens of different values that have uncertain
16 distributions in an internal dose calculation.
17 You have uncertainty in the metabolic models, you
18 have uncertainty in the values that were
19 measured, obtained -- you know, internal doses
20 are, by nature, indirect measurements. You can't
21 measure the internal dose to an organ with a
22 probe. You have to take a urine sample or a
23 fecal sample or something like that, so you have
24 the uncertainty in that measurement. You have
25 the uncertainty in once it gets in a lung, how

1 fast does it leave the lung. All these
2 parameters have uncertainty.

3 We didn't pick this number out of a hat,
4 though. I mean there are some scientific
5 publications out there that do point to the fact
6 that a geometric standard deviation of about
7 three is pretty reasonable. In fact, it's
8 probably a very fair, if not moderately claimant-
9 favorable, assumption. Using this assumption
10 results in a range of values spanning several
11 orders of magnitude at the -- there's a piece
12 missing here -- the 99 percent confidence
13 interval.

14 This is what I mean by that. This is a
15 lognormal distribution. This would be -- this is
16 not IREP. This is a program called Crystal Ball,
17 for those of you who may have Excel spreadsheets.

18 It's a nice little add-on package that you can
19 take and propagate uncertainty with any -- any
20 distribution that you can -- that you'd want to
21 use, using an Excel spreadsheet.

22 And so here's an example of -- let's say
23 that we did an internal dose calculation for an
24 organ and we thought that the best estimate, the
25 geometric mean of that distribution was 1,000

1 millirem, and we're going to assign it in the
2 IREP input file with a geometric standard
3 deviation of three. In practical terms, what
4 that means is we know this value within a range
5 of times three/divided by three. So we know this
6 value at one standard deviation, which is 65
7 percent of the values within a factor of three.
8 So by definition, at three standard deviations,
9 we know this within a factor of nine in either
10 direction. So in practice, what this means is
11 the 99th percentile upper tail would be sampled
12 at 9,000 millirem and the lower tail would be
13 1,000 divided by nine. I haven't done the math,
14 but it's somewhere above 100 millirem. So
15 somewhere slightly above 100 millirem to 9,000
16 millirem is the range of doses that we would
17 assign, given that our best estimate was 1,000
18 millirem.

19 That's a pretty wide range. I mean
20 we're basically saying we don't know this value
21 very well, which is the case for internal
22 dosimetry. There are a lot of uncertainties
23 about these calculations. Every single -- and
24 Dick can correct me if I'm wrong on this. I
25 think every single internal dose that we put in

1 has at least a GSD of three associated with it.

2 Now let me just turn to the uncertainty
3 in exposure models. Remember I said the
4 distribution used depends a lot on the
5 application. What I pointed out to you was the
6 uncertainty that we would use when we were doing
7 a somewhat fully-researched dose reconstruction,
8 something that we had external badge
9 measurements, we had urine samples. In many
10 cases for atomic weapons employers and others, we
11 have no real monitoring data for the individuals.

12 We have maybe a distribution of air samples. In
13 that case we would develop an exposure model.
14 That exposure model would be applied to the work
15 force.

16 Now there are a lot of different flavors
17 of exposure models one can develop. You can do,
18 in the case of Blockson Chemical -- or Bethlehem
19 Steel, an exposure model that covers all workers,
20 because we do not know at Bethlehem Steel where
21 the workers were in space and time in relation to
22 their work environment. We don't necessarily
23 know. That information was not collected with
24 any certainty.

25 So in that case, we will develop a

1 distribution from the air samples that will cover
2 the range of workers. And as I said, remember,
3 the best estimate -- our best estimate is -- the
4 best estimate for a triangular distribution would
5 be the mode. And so in the case of Bethlehem
6 Steel -- you can't see it very well on this
7 slide, but in the case of Bethlehem Steel, we
8 feel the best estimate for exposure was two times
9 the maximum allowable air concentration at that
10 facility. That was based on the air samples that
11 we had available at the plant.

12 And we've gone over this in previous
13 Board meetings. I'm just going to refresh your
14 memory. We also believe that our best estimate
15 for the maximum credible air concentration in
16 that facility is 1,000. This 1,000 was not even
17 taken at Bethlehem Steel. It was actually taken
18 at Simonds Saw & Steel at one of the processes,
19 but we felt that there was enough uncertainty in
20 our knowledge of the Bethlehem Steel air sample
21 distribution to incorporate this, just to make
22 sure that we covered the bases, that we weren't
23 biasing these results on the low side -- even
24 though, given -- remember, our best estimate of a
25 work exposure is two.

1 Some have led -- this has led some to
2 the conclusion that if your best estimate is two
3 -- this is the highest value on the curve -- then
4 that's what's being used to do the calculation of
5 probability of causation. That's what's used to
6 calc-- that's not even close to the reality of
7 the situation. It's a fairly complicated
8 scenario, but the best I can present it is that
9 what happens is in most cases what ends up being
10 used is -- the mean value of this distribution,
11 by the way, is 335 times the maximum allowable
12 concentration. The median value is really what
13 ends up being used, the value at which 50 percent
14 are below and 50 percent are above. So if you
15 have, for example, a cancer model that you're
16 running the calculation, it's almost equivalent
17 as if you put in 300 times the maximum allowable
18 air concentration in the probability -- in the
19 IREP calculation, is the way it's sampled.

20 That depends a lot, though, on the
21 uncertainty of the cancer model. The more
22 uncertain the cancer model, the more this 300
23 becomes the best estimate, because this
24 uncertainty is dwarfed by the uncertainty in the
25 cancer models and all the other coefficients.

1 Remember, I said that if your cancer model's very
2 uncertain, your best estimate -- the middle value
3 of the distribution ends up being the driving
4 value in the uncertainty distribution.

5 It varies, though, if the cancer models
6 are better known, then this starts to contribute.

7 But nonetheless, somewhere in this range is what
8 ends up being assigned to the workers.

9 We've developed several of these
10 exposure models for Bethlehem -- for some of the
11 AWEs, Bethlehem Steel and Huntington Pilot Plant
12 I think is one of them, Blockson has one of these
13 type exposure models. We believe we cover the
14 range. Again, if the probability of causation is
15 calculated to the 99th percentile, it's being
16 driven by some fairly high values that we believe
17 are claimant-favorable. And in fact these val--
18 this value is assigned to every single worker at
19 the plant, regardless of whether -- of where they
20 worked in the operation, if they were a rad
21 worker or not, 'cause we don't know, so we would
22 just assign that.

23 It's a fairly complicated issue, but I
24 think I hit the highlights there.

25 Let me back up. I think I missed one

1 point I wanted to make on internal. No, I guess
2 I didn't.

3 Okay, that's all I had prepared to talk
4 about formally. I thought this might spur some
5 conversation and discussion, so I'll stop there
6 and answer any questions.

7 DR. ZIEMER: Thank you, Jim. Very
8 stimulating presentation. Let's see what
9 questions we have this morning. Any -- yes, Jim
10 Melius.

11 DR. MELIUS: Yeah, this assumption of
12 internal dosimetry, the lognormally geometric
13 standard deviation of three, it would seem to me
14 that that would depend on the type of internal
15 dosimetry test. I mean I don't know much about -
16 - I've -- there aren't -- their distributions,
17 but it would seem to me that some are more
18 accurate than others.

19 DR. NETON: Yes.

20 DR. MELIUS: You know, like the
21 difference between a spot urine sample and a 24,
22 some -- I mean I'm sure there are others -- other
23 examples --

24 DR. NETON: Yeah.

25 DR. MELIUS: -- and so I guess my

1 question is -- is there really sort of a range of
2 -- should this be adjusted for different types of
3 tests or what's the...

4 DR. NETON: If we did adjust it, I'd say
5 we'd adjust it downward, we'd tighten it. This
6 would represent, in my mind, the upper range for
7 some of the worst type of analyses, like
8 plutonium -- the actinides, those -- so if we're
9 talking about taking a urine sample where one
10 millionth of the intake is being excreted in the
11 urine at any given time, that kind of situation.

12 I will say I mis-spoke slightly, though,
13 that the tritium model is much simpler, and we do
14 apply or are in the process of applying a
15 different uncertainty distribution for tritium
16 because that distributes itself uniformly through
17 the whole body. It mimics hydrogen or water by
18 that point, and so the water distribution of the
19 body in your excretion is known to a somewhat
20 better degree than a GSD of three, and we've
21 actually developed a Technical Information
22 Bulletin to address that.

23 I think the answer to your original
24 question is, I would say that there are better
25 estimates for some of the nuclides -- like cesium

1 is easier to measure, those type nuclides. This
2 GSD of three I think covers a myriad of
3 possibilities and does address, I think, the
4 worst case -- worst cases out there. In fact,
5 the analysis -- one of the analyses that we're
6 quoting was a GSD of three that was quoted based
7 on -- was it the atomic veterans analysis that
8 was done -- Health Physics published some
9 articles about -- this has nothing to do with the
10 DTRA program. This is a peer-reviewed analysis
11 of how well you could reconstruct doses from the
12 atomic veterans using things like lung counting
13 and urine sampling, and that's where a value -- a
14 GSD of three was provided.

15 DR. MELIUS: And how about -- that was -
16 - I'm thinking of changes over time and
17 techniques and...

18 DR. NETON: I think the overall
19 uncertainty in the measurement -- as you get
20 lower and lower and closer to background, of
21 course, uncertainty goes up. And as you go back
22 in time, the uncertainty goes up because the
23 detection limits weren't as good, maybe. But
24 really, those are small, compared to the
25 differences in metabolic models, breathing rates

1 -- you know, all those other factors. That's why
2 we're saying within a factor of ten, 20, 100, you
3 know. You incorporate all those uncertainties in
4 there and you end up with -- you know, I really
5 believe that you had 1,000 millirem but I can't
6 tell you if -- it's somewhere between 100
7 millirem and 9,000 millirem. We're pretty
8 certain we've got that bracketed. And under the
9 way the IREP program works, you punch that in
10 there, it's sampling those high values a certain
11 percentage of the time. And of course the
12 ultimate decision is basically the 99th
13 percentile. I can't say that that's going to
14 drive the PC calculation home, because again, it
15 may be -- even with that uncertainty, the over-
16 arching uncertainty in the calculation is the
17 risk model. These uncertain risk models -- I
18 can't over-emphasize their contribution. We have
19 had cases where the best estimate, the 50th
20 percentile, is in the low percentages -- one,
21 two, three percent; 99th percentile is over 50.
22 And that's not because of the dose
23 reconstruction. It's because the risk model, the
24 uncertainty and all the other -- the transfer
25 fac-- all that -- the radiation effectiveness

1 factors -- so in reality, this is one component
2 of the risk. I don't say it's a small component,
3 but it is in many cases. And where it is a major
4 component, I think we've got it covered with
5 these distributions.

6 DR. ZIEMER: Thank you. Mark.

7 MR. GRIFFON: Do -- yeah, I'd be
8 interested in the references, too, at some point,
9 for -- to support that GSD of three.

10 The other question I have was did -- I
11 know at one point IMBA -- the authors of IMBA
12 were going to construct some uncertainty analysis
13 functions into IMBA so that you could propagate
14 it. I'm not saying I disagree with the use of
15 this, but did they -- was that ever achieved or
16 have they --

17 DR. NETON: Well --

18 MR. GRIFFON: -- or does your current
19 version of IMBA --

20 DR. NETON: The current version --

21 MR. GRIFFON: -- allow you to...

22 DR. NETON: -- of IMBA has a function
23 that is a maximum likelihood estimator, but that
24 really addresses only one component and that is
25 the extrapolation of all the bioassay samples to

1 the intake. So if you have six bioassay samples
2 that you've taken on a person, they fit some
3 curve, and you're fitting these functions to it,
4 it will propagate or estimate the uncertainty in
5 that intake estimate. But that's -- again,
6 that's just one factor of all of these myriad of
7 factors that include metabolic models and all
8 that kind of stuff. So reality is, we don't --
9 we don't use that function. We've been sticking
10 with this.

11 We have looked at it. We've looked at
12 all kinds of possibilities, and we believe to be
13 the most straightforward is just to assign this
14 distribution to the internal dose.

15 DR. ZIEMER: Larry.

16 MR. ELLIOTT: Jim, would you comment on
17 the sensitivity analysis function of IREP and
18 what that really points to when you run that?

19 DR. NETON: Oh, okay. Yeah. Owen
20 Hoffman's sitting here. He's probably better
21 qualified to speak on that than I am, but there
22 is, under the advanced features of IREP, after
23 you do an IREP run, you can click on this button
24 and it will give you the relative contribution to
25 the overall uncertainty for a number of factors.

1 One is the cancer model, the risk model, and
2 then all those modifiers of the excess relative
3 risk function are in there. It also has the
4 contribution to the relati-- radiation
5 effectiveness factor and the contribution to the
6 radiation dose. So anyone can do this. YOU can
7 do an IREP run for any case that's been -- been
8 run, click on the advanced function -- advanced
9 features function and look at where -- you know,
10 what's driving the uncertainty in this
11 calculation. And that's what I've done. We've
12 done these sensitivity analyses and there's no
13 clear pattern. That's the problem. Because
14 there's so many -- the latency is built in there,
15 age at exposure, the incidence adjustments, all
16 those other factors.

17 I guess I'd like to ask Owen if he's got
18 anything else to add about the sensitivi-- the
19 advanced features. I mean did I portray that
20 properly, Owen, or...

21 DR. ZIEMER: Grab a mike there, please,
22 Owen.

23 DR. HOFFMAN: Actually it's a thrill for
24 me to sit in the back of the audience and hear
25 this presentation because it's been one of the --

1 my -- my areas of my career where I've been a
2 strong advocate is explicit incorporation of
3 uncertainty as probability distributions,
4 including the uncertainty on the dose.

5 Yes, in IREP there is an advanced
6 feature that does a sensitivity analysis. And
7 what that does is it -- it apportions the
8 uncertainties of the various components of IREP
9 and the uncertainty on the dose input to see
10 which contributes most to the overall spread of
11 values. Now that's not the same as to say which
12 one contributes most to the 99th percentile of
13 PC. So if you're interested in what contributes
14 most to the 99th percentile of PC, go back into
15 the model and fix a value as a constant and see
16 what difference it makes to the 99th percentile
17 of PC. It's a little bit more complicated
18 calculation.

19 I'd just like to mention, Jim, that in
20 some of our analysis of internal dosimetry for
21 some of the transuranics, you might get GSDs
22 somewhat greater than three. But for things like
23 iodine 131, strontium 90, cesium 137 and tritium,
24 the GSDs will be much lower than that, when
25 you're taking into account just the internal

1 dosimetric model. But that's exclusive of the
2 uncertainty in the intake. So oftentimes the
3 uncertainty in the intake will dominate over the
4 uncertainty in the internal dosimetric model.
5 But that won't necessarily be the case for things
6 like plutonium.

7 DR. NETON: Right. There's --
8 unfortunately there's not a ton of literature out
9 there on this. This is not an area that's been
10 explored in a lot of detail, and I believe that
11 we're somewhat blazing the trail here in this
12 area. And as we learn, we're certainly going to
13 modify.

14 DR. ZIEMER: Thank you, Owen, for that
15 added comment.

16 Other questions?

17 (No responses)

18 DR. ZIEMER: There appear to be none.
19 Thank you again, Jim. We appreciate that.

20 SCIENTIFIC RESEARCH ISSUES UPDATE

21 Next we're going to have an update on
22 scientific research issues, and this'll be
23 presented by Russ Henshaw.

24 MR. HENSHAW: Can you hear me? I don't
25 know if this is up...

1 Well, good morning to the Board. I'm
2 the epidemiologist with NIOSH Office of
3 Compensation Analysis and Support. I've been
4 more or less the one-man shop there for the three
5 years of the program's existence. We are hiring
6 another person, and I'll get into that a little
7 later.

8 I wanted to give you a brief update on
9 our research projects, where we are. I thought
10 I'd start with the lung cancer model. As you
11 know, we talked about that in prior meetings.
12 And just to recap, there is another version of
13 IREP known as NIH-IREP, which is maintained by
14 the National Cancer Institute, NCI. As you know,
15 late last year NCI revised their lung model
16 according to a published analysis of the Japanese
17 survivor data. It was a study published in
18 Radiation Research in 2003. Based in part on
19 that, but also on an additional specially-
20 commissioned analysis, and also they based it on
21 professional judgment by the scientists at NCI.

22 We have not followed suit on that.
23 Instead we've chosen to let the dust settle and
24 evaluate that model for possible application to
25 our EEOICPA-covered work force.

1 The difference between the -- then --
2 the change made in late 2003 -- the difference in
3 probability of causation between their version
4 and our version of IREP was mainly a difference
5 between smokers and non-smokers. In NIH-IREP the
6 PC results are generally more claimant-friendly
7 to male smokers and to females exposed at younger
8 ages. NIOSH-IREP remains generally more
9 claimant-friendly to male non-smokers and to
10 females exposed at older ages.

11 Well, we learned, since the last Board
12 meeting, that NCI has opted to make a further
13 change to their lung model. Specifically, they
14 decided to adjust for internal exposures -- that
15 is chronic exposures to alpha radiation. The
16 reported effect of that change is to smooth out
17 the differences in probability of causation
18 results at the 99th percentile credibility limit
19 for smokers and non-smokers. In fact, my
20 understanding is that the difference is
21 practically negligible -- or at least minimal.

22 I do have an update. I just learned
23 from talking with Owen at this meeting that that
24 change went into effect last week -- the change
25 in exposure to alpha radiation. So what we've

1 done when we learned about this, basically we put
2 it on hold and decided to wait until they made
3 their additional change, and then resume our
4 evaluation -- which we are in the process of
5 doing. We have a preliminary report from SENES
6 exploring the differences in the two models and
7 with certain recommendations, and that's in
8 internal review right now within OCAS.

9 Secondly, you might recall we have a
10 project going on re-evaluating DDREF, the dose
11 and dose rate effectiveness factor. Just for
12 those of you not familiar with that, I know the
13 Board is familiar with it, but DDREF is in effect
14 an adjustment factor that's built into IREP to
15 account for the differences in exposures of the
16 Japanese survivors compared to U.S. nuclear
17 weapons workers. Specifically, the Japanese
18 cohort was exposed primarily to acute doses of
19 radiation at relatively high dose rate --
20 basically intermediate rate to high. Whereas the
21 work force covered by our program -- exposed
22 mostly to a chronic lower dose rate radiation.
23 What DDREF adjustment does is basically account
24 for the presumption that the risk per unit dose
25 of radiation is less at low dose/low dose rate

1 than at acute high dose rate.

2 Now although the ICRP recommends a DDREF
3 of two, what we opted for in creating NIOSH-IREP
4 was to use a more claimant-friendly uncertainty
5 distribution -- there's actually two uncertainty
6 distributions in IREP. They apply to solid
7 tumors only, not to the leukemias. And our
8 distributions are weighted mostly between values
9 of one and two.

10 At any rate, that was a controversial
11 issue at the time the probability of causation
12 rule was published and at the time of creation of
13 NIOSH-IREP, as you all know.

14 I know this is of interest to the Board,
15 but it's also of great interest to us. We
16 thought it was time to take a fresh look at
17 DDREF, re-evaluate our assumptions and, based on
18 that re-evaluation, possibly propose an
19 adjustment to the DDREF.

20 Where we are right now is that we
21 received a preliminary report from SENES in May,
22 just two and a half or three months ago -- a very
23 complex and lengthy report, 88 pages long. It's
24 still within an internal review in OCAS. We hope
25 to complete our review and submit our comments to

1 SENES shortly -- hopefully, actually, within the
2 next week or two. I've got this month on that
3 slide. That may turn out to be true.

4 And ultimately we do intend to submit
5 any findings or recommendations to outside
6 experts, either via a panel or possibly
7 commission subject matter experts to
8 independently review our findings. We're not
9 sure yet. It's going to depend more or less on
10 the ultimate report after a back-and-forth
11 between OCAS and SENES.

12 I talked at a previous meeting about our
13 intention to upgrade NIOSH-IREP with the new
14 version of Analytica. Analytica is the software
15 package that functions as the computational
16 engine behind IREP. At the time I prepared this
17 slide, we had a projected implementation date of
18 August 20th. I'm happy to report that we did go
19 through with that on the 20th and transition went
20 smoothly, no reported problems. And our own
21 tests have shown that this new version actually
22 processes cases at two or three times as fast as
23 the old version. But more importantly, we can
24 now process cases with 500-plus rows of exposure
25 information. Previously that was very difficult

1 to do and took -- if it could be done at all, it
2 frequently took 30 or more minutes. And in
3 instances where we increased the simulation
4 sample size to 10,000, a claim simply could not
5 be processed at all. We reached a capacity limit
6 and a time-out problem.

7 We've also -- in conjunction with that,
8 we've changed the NIOSH-IREP version number to
9 5.3. The previous number was 5.2.1.

10 Also, as I mentioned in the e-mail to
11 the Board, the IREP summary reports now include
12 the Analytica version number printed on the top
13 of each summary report. Just -- avoid confusion,
14 there's -- there's an IREP version number and an
15 Analytica version number. Again, NIOSH-IREP is
16 at 5.3. Analytica is -- version number is 3.0.

17 We did begin interviewing for a research
18 health scientist position. We began mid-August.

19 Those interviews are actually still proceeding,
20 but we should have -- should have the whole
21 process wrapped up within a couple of weeks, I
22 believe. And barring unforeseen circumstances, I
23 would expect the new person to be on board prior
24 to the next Board meeting, and I assume will
25 probably be at the next Board meeting.

1 This person's primary duty will be
2 applied research, as opposed to unending pure
3 research. And I mention on the next slide, the
4 first project will be to conduct a feasibility
5 study of current occupational dose-response data.

6 Incorporation of occupational studies
7 into our risk models has been a primary interest
8 of the Board. It is of major interest to OCAS,
9 as well. We will begin that project this year.
10 I do want to just remind everyone, though, that
11 the probability of causation rule went into
12 effect just two years ago. At the time the rule
13 was promulgated, the decision had been made by
14 NIOSH that the current state of knowledge of U.S.
15 occupational studies was insufficient to
16 incorporate it into our risk models.

17 I might add also as recently as late
18 last year when NCI is-- the NCI/CDC working group
19 issued its report to revise the 1985 radioepi
20 tables, they commented that at that time, less
21 than a year ago, that estimates based on low dose
22 studies are far too imprecise to be used in risk
23 modeling. Well, that may be the case, but
24 nonetheless, we do think it's time to take
25 another look at it, and we'll begin with a

1 feasibility study. And if the -- that study
2 indicates that there is a sufficient quality and
3 quantity of dose-response data among occupational
4 cohorts, we will launch into the next phase to --
5 which would be to incorporate that data as a
6 supplement to our risk models wherever that may
7 be possible.

8 Grouping of rare and miscellaneous
9 cancers, that was another priority item that the
10 Board identified. As you recall, the cancers
11 were originally allocated to risk groups based on
12 epidemiological data mostly, but also biological
13 plausibility and uncertainties. And I do want to
14 clarify, by the way, an issue that came up in the
15 subcommittee meeting two days ago when Larry
16 asked a question about the risk group for rare
17 and miscellaneous cancers. There are two things
18 going on here. There are 32 IREP risk models,
19 but each of those models falls into one of three
20 major risk groups. Or if it doesn't, into a
21 separate -- a separate risk group. And I just
22 want to summarize those risk groups now.

23 The three main ones we call -- group one
24 is a group that includes breast cancer, digestive
25 cancers, and it depends -- that risk model

1 depends on age at exposure and age at diagnosis.

2 The group two cancers depend on age at
3 exposure and age at diagnosis, but also
4 incorporates an age-independent excess relative
5 risk per sievert, as multiplied by an age-
6 dependent modifying factor. And that group
7 includes cancers such as bladder, connective
8 tissue, esophagus, eye, many other sites.

9 Group three cancers characteristic --
10 the major characteristic is that the excess
11 relative risk per sievert is constant for all
12 ages at exposure and attained age. There's no
13 age dependency. And that group includes female
14 genitalia, less ovary, and lung cancer.

15 There are nine additional risk models
16 that we loosely call group four, but each has a
17 unique -- a unique risk model.

18 I might add that I think this
19 exploration of -- or re-evaluation of how these
20 cancers are grouped I believe dovetails into the
21 feasibility study of occupational cohorts. I
22 don't see why we can't look at both of these
23 issues, if not simultaneously, at least in
24 conjunction with each other. And I think there's
25 a good deal of interplay there that needs to be

1 studied. In fact, the more I think about this, I
2 don't think we can really look at the two issues
3 independently.

4 I have on the slide that that project is
5 in the planning stage, but really it's really in
6 the beginning stages. I expect a preliminary
7 report from SENES very shortly.

8 Projects I did not mention on the slides
9 -- three, to be specific. This is late-breaking
10 news. We intend to conduct a review of the
11 choice of organ sites for dose reconstruction.
12 Again, this is not for IREP risk modeling, but
13 the choice of the appropriate organ for
14 conducting the dose reconstruction. There may be
15 instances, for example, where the choice of organ
16 for dose reconstruction possibly conflicts with
17 the way the respective IREP cancer model is
18 allocated to a risk group. There may be
19 instances where one could choose between two or
20 three organ sites for conducting dose
21 reconstruction, and maybe it's a judgment call.
22 We want to re-evaluate those situations and make
23 sure that if we're using an organ that's perhaps
24 less claimant-friendly than another that there's
25 a sufficient scientific rationale for that. Or

1 if not, change it.

2 We also need to look at the -- our
3 latency adjustment for bone cancer. That's a --
4 there's a current difference in the latency
5 adjustments in NIOSH-IREP as opposed to NIH-IREP.

6 NCI decided that the bone cancer model -- the
7 latency adjustment for the bone cancer model more
8 properly falls into a latency adjustment used for
9 thyroid cancer. We have not made that change,
10 but we need to evaluate that and make a decision.

11 And finally, as you all know, the Health
12 Energy-related Research Branch in NIOSH received
13 some funds to conduct studies of CLL. They had a
14 public meeting last month. Three representatives
15 from OCAS attended that meeting and I guess --
16 not much more we can say about that at this point
17 except that presumably there'll be a report
18 issued from that meeting and we will proceed from
19 there.

20 That's really all I have at this time.
21 I'd be happy to entertain any questions.

22 DR. ZIEMER: Russ, would you mind just
23 repeating the variables on your second group?

24 MR. HENSHAW: Sure. I didn't name all
25 of them. It's quite a bit, but --

1 DR. ZIEMER: The main ones that you had
2 identified.

3 MR. HENSHAW: Bladder cancer --

4 DR. ZIEMER: No, not the organs, but the
5 variables.

6 MR. HENSHAW: Oh, I'm sorry. The excess
7 relative risk per sievert depends on age at
8 exposure and age at diagnosis, but an age-
9 independent excess relative risk per sievert is
10 multiplied by an age-dependent modifying factor.

11 DR. ZIEMER: Thank you.

12 MR. HENSHAW: Group three is the only
13 one of the three main groups with no --

14 DR. ZIEMER: Constant with age.

15 MR. HENSHAW: -- dependency on age.

16 DR. ZIEMER: Thank you. Other questions
17 or comments? Yes, Jim.

18 DR. MELIUS: Just more of a comment.
19 Would it be possible on the -- since we're -- I
20 think we're meeting in Washington next time -- to
21 get a presentation from NCI or whoever needs to
22 be involved on the smoking adjustment lung cancer
23 issue? I don't know if the timing's right in
24 terms of your reports that you're receiving, but
25 there might be an opportunity to have them come

1 and explain it.

2 DR. ZIEMER: Have they basically
3 finished their work on that issue or --

4 MR. HENSHAW: My understanding is that
5 final adjustment just went into effect last week.

6 They call their report an interim report,
7 pending release of BEIR VII and so forth, but --
8 yeah. The last I heard, by the way, is that BEIR
9 VII is expected out late this year or early next
10 year. Does anyone have an update on that?

11 UNIDENTIFIED: We've heard that before.

12 DR. MELIUS: As Cori says, check's in
13 the mail.

14 MR. HENSHAW: I don't know. I mean I
15 guess it's possible. I guess we certainly...

16 DR. ZIEMER: I can almost assure you
17 BEIR VII will not be out this year.

18 MR. ELLIOTT: Yes, we'll -- we'll look
19 at that and -- I think it depends -- it would be
20 nice if we had something to present as a
21 companion so that you can make the comparison and
22 make a contrast and see the full gamut.

23 DR. MELIUS: Yeah, that's why I was
24 asking were you going to be ready.

25 MR. ELLIOTT: Yeah, well --

1 DR. MELIUS: And same thing -- I mean at
2 some point a briefing on the SENES work on
3 (Inaudible) that would be good.

4 MR. ELLIOTT: Of course. All of this --
5 let me just speak to process. You know, we
6 develop our work and we put it in front of
7 subject matter experts for peer review and
8 comment, as we've done with our probability of
9 causation and the IREP development that we did
10 when we were in rulemaking. You saw those
11 subject matter expert comments. You had them
12 available to you to weigh in your deliberations.

13 That's the same process we would use for any
14 substantive or substantial modification we would
15 make to any risk model or any dose reconstruction
16 methodology. We'd get subject matter expert and
17 peer review comments for your benefit when we
18 bring a proposal before you to evaluate.

19 DR. MELIUS: It's just that there -- no,
20 I agree with the procedure. I just think -- may
21 be a way of sort of briefing us as you go along
22 so -- rather than all at once.

23 MR. ELLIOTT: Sure.

24 DR. MELIUS: For example, the DDREF, if
25 -- if there's a certain finding or part of report

1 that's -- has some significant implications --

2 MR. ELLIOTT: I agree. As you can tell,
3 we're putting more resources behind this. We're
4 putting more momentum into these various research
5 questions you have raised as primary questions
6 for us. I think it's appropriate to keep a
7 standing agenda item here on research issues and
8 have Russ or his other colleagues come before you
9 and present status now. Okay?

10 DR. ZIEMER: Okay. Any additional
11 questions for Russ?

12 (No responses)

13 DR. ZIEMER: Apparently not. Thank
14 you, Russ, appreciate the input.

15 The next item on the agenda is called
16 subcommittee status, and -- a comfort break has
17 been requested.

18 MR. PRESLEY: Good idea.

19 DR. ZIEMER: Okay, we'll take a comfort
20 break.

21 (Whereupon, a recess was taken.)

22 SUBCOMMITTEE STATUS

23 DR. ZIEMER: Okay, let's reassemble.

24 The next item on the agenda is called
25 subcommittee status. What we'll do is simply

1 start with an update on the charter, and then
2 move into the report of the subcommittee.

3 You should have received in your packet
4 or -- I think in your packet, or as a handout,
5 the final clean version of the subcommittee
6 charter. The subcommittee charter was approved
7 by this Board at the last meeting. You recall
8 that it had to be submitted to the --

9 MR. ELLIOTT: Committee management.

10 DR. ZIEMER: -- committee management
11 office -- I was trying to get the right name --
12 for their approval, and that now has been
13 approved and the sub-- or the charter of the
14 subcommittee is in effect. So it requires no
15 action. I just wanted to make sure everybody has
16 a copy of it, and then to remind you that under
17 the -- well first, anyone need a copy of the
18 subcommittee charter?

19 MR. ELLIOTT: It's under your -- it's
20 under your tab which says roster, charter and
21 subcommittee establishment. It should be there.

22 You're going to first see the roster of the
23 Board, then the charter of the Board and then the
24 memo that establishes the subcommittee.

25 DR. ZIEMER: Memo dated June 21st.

1 Okay? Now notice that the membership of the
2 subcommittee is identified as being the
3 attachment, and the attachment is the Board. So
4 all members of the Board are members of the
5 subcommittee. So the way that this works is that
6 for a particular meeting, we can select any
7 subset of the Board to serve as the subcommittee
8 for a particular meeting, but it will not be the
9 whole Board at any given time. We still will
10 have a number -- which is somewhere spelled out
11 here -- the Chair plus three members and the
12 Designated Federal Official. So there's four
13 members of the Board at any given meeting, plus
14 the Designated Federal Official.

15 Any questions on the charter itself?

16 (No responses)

17 DR. ZIEMER: Okay, so the charter is in
18 effect. The subcommittee did meet on Monday of
19 this week. The individuals who met for the first
20 time as the subcommittee had also comprised a
21 working group that met a month ago in Cincinnati
22 to develop some materials for the subcommittee to
23 review and develop further, and then ultimately
24 for that -- for a recommendation to come to the
25 Board on procedures for selection of cases to be

1 reviewed as part of our audit process.

2 So what this Board needs to do now is to
3 receive from the subcommittee its recommendation
4 on how to select the cases and a process for
5 reviewing those cases. In that connection, there
6 is a handout which consists of two pages, and the
7 handout doesn't really have a title on it --
8 well, it says procedures for selecting and
9 tracking dose reconstruction pages -- or cases, I
10 guess that's the title -- dated 8/24 and it has
11 as a second page a kind of flow chart. And
12 actually the flow chart is the main thing that
13 we'll be focusing on and the -- what looks like
14 the first page is really an explanation of how
15 the flow chart works. Now --

16 DR. MELIUS: Excuse me, I'm missing
17 that.

18 DR. ZIEMER: You're missing that. Okay,
19 let's make sure we got a copy for Dr. Melius.

20 DR. MELIUS: No, never mind. Wanda
21 helped me. I put it in the discard pile.

22 DR. ZIEMER: Well, we weren't sure it
23 was a very attractive-looking document, but that
24 confirms -- we've got to dress these up in the
25 future.

1 Now if you'll keep that document at
2 hand, what we want to do is walk through that,
3 show you what the thinking of the subcommittee
4 is, and this will become a recommendation and
5 basically a motion from the subcommittee for the
6 Board to adopt this as a procedure.

7 Now the person who really helped us sort
8 of get this in usable shape was Mark, and Mark,
9 if I can call on you to walk us through the
10 document and explain the concept here. And as
11 Mark does this, I think it would be helpful if
12 the Board would recall that we talked about a
13 matrix of kinds of dose reconstructions, the
14 matrix being an array that represents various
15 facilities, various kinds of cancers, various
16 types of workers, various levels of probability
17 of causation, all of the parameters of interest.

18 And the thinking being that we would like to
19 have a sampling from all of this -- different
20 parts of this array in various amounts, depending
21 on weighting.

22 For example, a facility that has a lots
23 of claims might therefore have more samples
24 tested or reviewed than a facility with very few
25 claims. But in any event, have the matrix in

1 your mind as Mark walks us through the process.
2 Mark.

3 MR. GRIFFON: My third attempt at this.

4 We did this on the subcommittee level, too.

5 Yeah, I guess the -- that is important
6 to keep in mind is that I think, you know, at the
7 end of the day -- in this flow sheet there's some
8 parameters of interest defined here, and what I -
9 - what I envision happening is at the end of the
10 day we want to make sure we can fill this matrix
11 with a sampling of -- you know, with cases in
12 those relative amounts by the time we're finished
13 sampling the whole set of available claims, of
14 available cases.

15 So having said that, we thought we
16 needed -- this is sort of to establish a
17 procedure of how we're going to first select
18 cases, and then sort of drop them in that matrix
19 and fill our matrix up. So the first step at the
20 top of that flow sheet -- it's easiest to follow
21 this flow sheet, I think -- is to select the
22 cases, really just using a simple random number-
23 generator type selection process, and these will
24 be of the available completed cases, finalized
25 cases. Am I using the right terminology, Larry?

1 The --

2 MR. ELLIOTT: I think they -- to be
3 correct, it's the cases that have been
4 adjudicated to the point where there's a final
5 decision proffered.

6 MR. GRIFFON: Right, which I think
7 currently is somewhere around --

8 MR. ELLIOTT: Fourteen hundred, I
9 believe, that have achieved that state at DOL.

10 MR. GRIFFON: So you know, we're
11 thinking -- and actually we did a few trials of
12 this -- just have a random sampling of those, no
13 criteria, no stratification at all. And then
14 take those random samples and run them through
15 our parameters here and fill our matrix and --
16 and this is where we build in the flexibility so
17 it's not a strictly statistical sampling method,
18 but we as the Board or if we decide to delegate
19 this to a subcommittee, but right now I think we
20 as the Board would then look at these cases and
21 have the information on these listed parameters
22 below, and go down the list in order that they
23 came up in a random selection process and decide
24 -- you know, we'll take the cases and fill our
25 matrix, but then if we get to a point where we've

1 got too many, in our view, of one certain type,
2 then we can go to the next case. You know, we
3 can exclude that, put that back in the pool, so
4 to speak. Okay? So that's generally how it's
5 working.

6 We looked at these parameters, as you go
7 down this flow sheet -- these are the primary
8 parameters where we're interested in looking at
9 in sort -- sort of a -- I look at them as
10 descriptive statistics of the cases. And the
11 reason these -- one, two, three, four -- the
12 reason these five are highlighted is because
13 these were criteria that we were interested in
14 that were also searchable on the NOCTS system on
15 NIOSH's database.

16 POC categ-- and then we had some
17 deliberations in our subcommittee about the
18 appropriate ranges and the percentages of
19 samples, and you can see to the right of each box
20 on this flow sheet there's a description where we
21 sort of came down and this -- this, we should
22 say, is preliminary and we may want to adjust
23 this in a later date, or even today if you don't
24 agree with it. But this is where we came down on
25 sort of the appropriate number of samples by

1 grouping. So for POC, zero to 44.9 percent, we
2 went -- at the end of the day, when we fill our
3 matrix, we want 40 percent of all of our cases to
4 be within that group. From 45 to 49.9, we see
5 that as a very sensitive, important area. We
6 want a sampling of 40 percent, at the end of the
7 day, to be out of that group. And the rationale
8 there is -- you know, a couple of things. I
9 think there -- there's some assumptions when a
10 POC gets over 45 percent, the efficiency rules
11 are, I believe, turned off with NIOSH and they go
12 back and do a more refined dose reconstruction,
13 so there's some different things that come into
14 play. Also they're closer to the 50 percent
15 award area, so that's why we weighted that a
16 little higher. And then greater than 50 percent,
17 we certainly want to sample some of those cases,
18 as well, but we weighted it a little lower, 20
19 percent.

20 And then the next major criteria,
21 facility, and the note says sample based
22 proportionately on the total number of claims
23 from all DOE facilities. And we've got this
24 listing, and I've -- on an Excel spreadsheet I
25 sort of went through this and they way I've --

1 the way I've looked at it now, I tried to modify
2 it slightly last night to be consistent with Jim
3 Neton's presentation where he -- he's saying
4 roughly -- when they have more than 40 cases for
5 a site, around that area, that's when they're
6 tending to do a full site profile, and -- and it
7 made sense to me to -- we needed a cutoff.

8 Obviously you can't sample 2.45 percent for a
9 site that only has, you know, one or two claims,
10 so we needed some cutoff. At 40, you're looking
11 at one case. So you know, the way I laid it out
12 right now, I lined -- did a list of all of our
13 facilities which -- where currently they have
14 more than 40 claims. And now that's going to
15 change, obviously, but just -- just for a cutoff
16 at this point, I chose that, and we'd sample --

17 DR. ZIEMER: And just for clarity, for
18 example then, if -- if Idaho had ten percent of
19 the total claims in the system, then we would
20 expect in our matrix to -- out of our total
21 sample, ten percent of that to be Idaho.

22 MR. GRIFFON: Right, right. And that's
23 the propor-- yeah, the proportional sampling
24 there is that it's proportional to the number of
25 claims for those -- for the sites, so the sites

1 with higher numbers of claims, we'd sample in
2 accordance with the claim percentage of the total
3 claims in the system.

4 And then at the -- the last grouping
5 there is -- is a group of all the sites with less
6 -- you know, less than a certain point, maybe
7 less than 40 overall claims in the system. And
8 we grouped them all together and from that pool
9 we'd do a 2.5 percent sample, which is where we
10 wanted to end up, if you remember, in our overall
11 sampling is 2.5 percent. But the other ones, the
12 -- the larger sites, we'd -- we'd sample
13 proportionately, you're right, Paul. Thanks.

14 The next criteria, decade first employed
15 -- again, these -- we weighted by decade and, you
16 know, this was -- you know, based -- I guess we
17 had discussions in the subcommittee, you know,
18 based on our experience at the sites. And where
19 we thought that there'd be more complex, more
20 difficult cases, but -- and also more, you know,
21 likely higher exposures, we tended to weight
22 those decades a little higher. But we didn't
23 want to exclude -- you know, we certainly don't
24 want to exclude the 1980's, or even the nineties
25 -- nineties and beyond, I guess that would be,

1 so...

2 And duration of employment the same way,
3 you can see the breakout there. We -- we
4 weighted zero to one year fairly heavily because
5 of the concern of some workers that may -- you
6 know, may have a short term at some sites, but
7 they may have -- they may fall into that category
8 of the unmonitored question, so there may be some
9 unique circumstances that we want to look at.
10 That's why -- that was our sort of rationale for
11 that.

12 And the final is the risk model, which
13 is basically the IREP risk model, the type of
14 cancer. And -- and here we left this pretty
15 open. The reason we didn't want to necessarily
16 say a proportional sampling is because I think if
17 we look at the current statistics -- I'm not sure
18 if I have the latest ones, but there are some
19 fairly common cancers -- skin cancer, prostate
20 cancer -- that we may not want to do a
21 proportional sampling of those types of cases
22 because they're -- at least for prostate it's a
23 very -- fairly non-radiosensitive, too, so how
24 much do we want to look at -- you know, we may
25 not want to do a proportional sampling -- we do

1 say in here, though, that our intent is to
2 examine cases representing each type of model, at
3 least some cases exam-- you know, related to each
4 type of model. So that's kind of still open.

5 DR. ZIEMER: And I might insert here,
6 and I think this Board could at some point decide
7 on what that distribution should be. Our thought
8 was at the front end, with say 20 or so sample
9 cases, we may not try to -- we're not going to
10 fill all these boxes anyway. But the other thing
11 is, we -- it occurs to me that the three overall
12 categories that Russ described to us earlier may
13 be a starting point to subdivide these because
14 they look at the variables in different ways and
15 we may want to look at that and break those three
16 categories into some distribution. But we can --

17 MR. GRIFFON: Uh-huh, there may be other
18 ways to -- yeah. And finally, and not to be
19 overlooked -- it probably shouldn't be in a
20 little box in the lower right-hand corner, but I
21 apologize on the format -- there's other criteria
22 that we certainly have discussed on this Board
23 and in our subcommittee that we think are pretty
24 important parameters in, you know, looking at
25 those cases where coworker data was used. The

1 thing about these criteria listed in the corner
2 is that they're -- currently none of these are
3 searchable criteria on the NIOSH database, so we
4 can't -- total ca-- you know, we can't get the
5 descriptive statistic when -- when we get a
6 printout of random cases, the descriptors --
7 we'll get POC, we'll get facility, decade,
8 duration and risk model, but we can't get these
9 other parameters, so we'd have to open the case.

10 So what we -- we feel that we want to -- at the
11 outset we want to track this information, or have
12 our -- our subcontractor track this information
13 so that we get a sense of where -- and the other
14 -- obviously the other parameters, just to look
15 down them, monitored versus unmonitored is a
16 important one. Job category is certainly
17 something that we --

18 DR. ZIEMER: And once we start tracking
19 it, we can assure ourselves that we are sampling
20 across these parameters, as well.

21 MR. GRIFFON: Right.

22 DR. ZIEMER: A priori we can't get at
23 the data.

24 MR. GRIFFON: Right. And I guess that -
25 - that's -- I think that's it. That's --

1 describes what we thought of as the process,
2 Paul, unless you --

3 DR. ZIEMER: Right, and if you --

4 MR. GRIFFON: -- have further
5 explanation.

6 DR. ZIEMER: -- look at the first page
7 now in terms of how it's done, we actually would
8 ask NIOSH to simply use the random number
9 generator to generate a group of cases. This
10 Board or the subcommittee would then look at that
11 list of cases and -- and see how they fit into
12 the matrix, and then we could either accept or
13 reject a case. But we would have a list of cases
14 and you would just move on down through the list.

15 The other thing is that once the cases
16 are selected -- and I'm not sure that -- says so
17 here, but what the subcommittee talked about was
18 having -- for each case having two members of
19 this Board being primarily responsible for that
20 case, coupled with a contractor person who would
21 work up the case, because we're not all dosimetry
22 experts. We talked about that --

23 MR. GRIFFON: Yeah, that -- I didn't put
24 some of that -- I know we had discussions about
25 the panels and the interface with the

1 subcontractor. That -- I think -- if we want to
2 modify that, it should be in our other procedure,
3 which I don't even remember the name of it, but
4 we had a case processing procedure, I believe,
5 and this -- I just looked at --

6 DR. ZIEMER: This is the tracking --

7 MR. GRIFFON: -- (Inaudible) I didn't
8 want to overlap it with the other one, yeah,
9 so...

10 DR. ZIEMER: Okay.

11 MR. ELLIOTT: I don't think that it's
12 any different than what you've proposed in your
13 process procedure, other than what we've agreed
14 to -- and certainly the Board has to weigh in on
15 this -- was to -- once you select the case, we
16 would create a compact disk that had your set of
17 cases for you, as a member, to look at with all
18 information in it. It's not redacted, so it'll
19 be a Privacy Act-controlled disk, if you will,
20 that would be delivered to you and the
21 contractor. I think that's the only difference -
22 -

23 MR. GRIFFON: Yeah, I think we -- we
24 clarif-- I mean I think some of the discussion we
25 had in the subcommittee was sort of -- now that

1 we -- 'cause we -- SCA was represented in the
2 audience and we had a little further discussion
3 of almost logistics, how's this going to work,
4 you know, so we envisioned sort of a -- you know,
5 and we still might want to --

6 DR. ZIEMER: But we --

7 MR. GRIFFON: -- write this down within
8 our procedure, but the panel members could al--
9 you know, conference call in with SCA during the
10 development. And then at some point when the
11 cases are brought back to the Board, we talked
12 about having a first day closed session where
13 specific cases could be discussed and ca-- you
14 know, case reports, but also where aggregate data
15 -- an aggregate data report might be brought by
16 SCA to that meeting, and then, you know, in
17 closed session we could discuss the individual
18 cases and the aggregate report, and then in open
19 session present the aggregate findings where we
20 don't -- where we can't -- can't discuss privacy
21 information. So that's sort of -- we talked
22 about that kind of process stuff.

23 DR. ZIEMER: Well, let's focus on the
24 selection procedure then. So this recommendation
25 comes as a -- or this comes as a recommendation

1 from the subcommittee and therefore is considered
2 a motion before the Board to accept or to modify.

3 So this now is open for discussion. Jim Melius

4 --

5 DR. MELIUS: Okay --

6 DR. ZIEMER: -- then Wanda, then Rich.

7 DR. MELIUS: I would have -- I like the
8 proposal. I -- the only one I would question is
9 the over-weighting on the duration of employment
10 towards few years. You have 40 percent of the
11 cases would have less than five years of work at
12 a facility, and that seems to me to be high. And
13 I agree that we want to pick up some people with
14 short dura-- short duration, but seems to me we
15 would learn more -- there'd be more work involved
16 I guess, but we would learn more from looking at
17 people with longer duration of exposure.

18 DR. ZIEMER: And this is a good point,
19 and one -- one thing that we should be cognizant
20 of is that, to some extent, these are gut
21 feeling, arbitrary numbers. And also we don't at
22 this point know how this distribution compares
23 with the claim distribution on longevity of the
24 job and so on, whether -- whether we are really
25 greatly over-sampling, even beyond what it looks

1 like here, compared to the number of claims. So
2 it's a point well taken and if someone wishes to
3 revise the numbers, it's quite appropriate.

4 DR. MELIUS: Yeah, and I mean I was just
5 trying to look at -- as I looked at this, think
6 through -- well, where are people going to fit,
7 and it dep-- somewhat depends on sort of the --
8 you know, the order -- I mean that these are
9 going to interact and not going to be -- same, so
10 will people with short duration of work more
11 likely be people who have a lower probability of
12 causation, 'cause they'd have lower exposures, so
13 -- yeah, but I'm afraid if we try to overfill on
14 that particular thing, I think we're going to end
15 up with a -- I'm not sure a very representative
16 population, nor do I think we get a good look at
17 what the dose reconstructors do.

18 MR. ELLIOTT: Certainly with AWEs you
19 have a contained employment period that is --
20 that is reconstructed against. And it's not --
21 those are not, you know, decades. Those are
22 usually in short number of years, so --

23 DR. MELIUS: Yeah, that was what I was
24 going to mention is that another issue is going
25 to be for different facilities, and somewhat

1 depends on sort of the order you go through in
2 terms of selection as we fill this in. But maybe
3 that's something we can adjust later on, but I
4 just -- it's the one I thought -- I was a little
5 concerned about.

6 DR. ZIEMER: You're not proposing a
7 change at the moment, or are you proposing a
8 change?

9 DR. MELIUS: Well, I'd like to get some
10 more discussion.

11 DR. ZIEMER: Let's see, I guess Wanda
12 next.

13 MS. MUNN: I'm glad to have heard the
14 explanation because I was -- I was concerned over
15 whether the random number generator was going to
16 be used for specific sites when we first started
17 out, or later on whether we were going to do one
18 -- the sites, as for example, site profiles were
19 complete. And so I'm -- I think -- my question
20 is probably answered -- the first question was
21 answered by relating table one more directly to
22 the first statement in the procedure that was
23 given.

24 But I do have a little concern with the
25 note down at the bottom. It was my understanding

1 from all the information that we've heard here
2 that job category is something that's almost
3 impossible to tie down for most of the claimants.

4 DR. ZIEMER: The issue has to do with
5 what words are used to describe the job.

6 MS. MUNN: What types --

7 DR. ZIEMER: However, once you get a
8 case and open it, you can figure out, for
9 example, whether it's a welder or a lab
10 technician or whatever it may be. But a given
11 kind of job sometimes has multiple names and
12 maybe different names at different sites. But I
13 think our thinking was that we could at least
14 separate out kinds of workers, like engineers or
15 construction workers or maybe some broad
16 categories, even though -- we can't certainly
17 sort against them. Once we have a case open, you
18 can figure out what the person did.

19 MS. MUNN: Yeah, and my -- my point is,
20 if we're going to do that, probably we should
21 establish as a goal -- one of the things that the
22 committee is going to have to do is to make some
23 judgment with respect to the broad job category.

24 MR. GRIFFON: Yeah, and how to decide --
25 I guess how to decide primary job or something

1 like that, I mean --

2 MS. MUNN: Yeah.

3 MR. GRIFFON: Yeah, 'cause that could
4 become an issue. I mean there's different
5 approaches to that.

6 MS. MUNN: I think we probably need to
7 make it clear in our procedure that that will
8 have to be a judgment made by -- by the committee
9 'cause I don't see any other way you're going to
10 get that done.

11 MR. GRIFFON: Right.

12 MS. MUNN: My only concern then left
13 with the procedure itself is in the very last
14 item in item six when you say this information
15 will include only the statistics of the case
16 reviewed. Only the statistics probably mean
17 different things to different people, and for
18 some, that would include the facility, that would
19 include diagnoses, that would include month of
20 employment, all of which are a part of the flow
21 chart over here, but is that indeed -- are the
22 items listed on the flow chart indeed the items
23 that we want to present in our case presentation,
24 or --

25 DR. ZIEMER: Let me try to answer that

1 in part. The idea was that once the individual
2 cases are reviewed and the whole thing is rolled
3 up, what would come to the full Board in open
4 meeting would be a report that might take the
5 form of -- that 25 cases have been reviewed and
6 in 20 of these cases there were no issues, in
7 three cases there was questions raised about
8 something -- no cases would be specifically
9 identified in open session, simply a kind of a
10 statistical rollup of the overall picture.

11 MR. GRIFFON: I think may--

12 DR. ZIEMER: In several cases this issue
13 arose.

14 MR. GRIFFON: I think maybe a better way
15 to phrase it is like summary findings or
16 something like that --

17 MS. MUNN: Summary findings.

18 MR. GRIFFON: -- instead of statistics
19 of cases.

20 MS. MUNN: Yeah.

21 MR. GRIFFON: If I can propose to
22 include -- instead of --

23 DR. ZIEMER: Yeah, summary findings --

24 MR. GRIFFON: -- those statistics, yeah.

25 DR. ZIEMER: -- would that be more

1 acceptable?

2 MS. MUNN: It would be to me.

3 DR. ZIEMER: I take it by consent that
4 the words "summary findings" would be substituted
5 here for "statistics". Thank you.

6 MS. MUNN: And now being a -- being a
7 detail junkie, I guess, I have a tendency to
8 think in process, so it concerns me a little bit
9 on how our random number generator is going to
10 work from NIOSH's point of view. That is to say
11 is there going to be a possibility that the same
12 case may be reviewed more than once --

13 DR. ZIEMER: No.

14 MS. MUNN: -- or is that number -- is
15 NIOSH going to have to drop that number out of
16 their generator once it's been chosen?

17 DR. ZIEMER: Once that case is out, it's
18 our understanding that the -- I mean if it -- if
19 it showed up again, it would simply be omitted --
20 or deleted.

21 MS. MUNN: Because our procedure doesn't
22 say so.

23 DR. ZIEMER: Okay. Okay, we can
24 certainly add that. The intent is that the cases
25 that have been reviewed are out of the pool.

1 MS. MUNN: Once done, it's done. Yeah.

2 DR. ZIEMER: So we can add a phrase to
3 include that, yes. Thank you.

4 Rich, you were next?

5 MR. ESPINOSA: Yeah, mine was a -- kind
6 of on the same lines as Wanda for job categories.
7 I was just kind of wondering how defined it was
8 going to get, and so...

9 DR. ZIEMER: Yeah. I think the answer
10 is we don't know. We will have to get some cases
11 and start to see what -- what those look like and
12 try to sort them. In other words, we're saying
13 the intent is to sort or to track, but it's not a
14 -- it currently is -- the -- searchable variable
15 at the moment, yeah. I guess Jim was next, and
16 then Roy.

17 DR. MELIUS: Back to my issue on
18 duration of employment, I'm assuming -- you
19 didn't have any really data to base this on --

20 DR. ZIEMER: No.

21 DR. MELIUS: -- in terms of that?

22 DR. ZIEMER: No.

23 DR. MELIUS: So rather than trying to
24 propose that -- to make some changes in
25 particular things now, I think -- you know, we're

1 -- at this point it rather -- with the first
2 whatever -- it's 14 or whatever we have, I think
3 you'd be able to get some summary statistics off
4 of that in -- for these different parameters and
5 have the subcommittee or whoever look at that at
6 the point in time so that we can get a better
7 handle on what's out there --

8 DR. ZIEMER: Keep in mind, this is
9 basically conceptual in the sense that the Board
10 could -- whatever you adopt could be modified at
11 any later date.

12 DR. MELIUS: Yeah, and that --

13 DR. ZIEMER: Once you get some
14 experience and say well, we need to adjust the
15 matrix.

16 DR. MELIUS: Yeah.

17 DR. ZIEMER: We need to sample more in
18 this area or some other area.

19 MR. GRIFFON: Actually I've --

20 DR. ZIEMER: In fact, you could go back
21 and say we don't have enough cases from some site
22 and you could now sample randomly within a site.

23 DR. MELIUS: Uh-huh.

24 DR. ZIEMER: The subcommittee actually
25 tested the process. We had some sample lists

1 generated by both random number and by
2 probability of causation category to see what
3 those looked like. And for example, if you use
4 pure random numbers, you see an array of cases
5 which very much reflects the number of cases in
6 the different sites.

7 DR. MELIUS: Uh-huh.

8 DR. ZIEMER: Obviously it doesn't track
9 exactly because you can get clustering. This --
10 it's a little like Las Vegas, you know. You
11 don't -- you may get a run of something.

12 MR. GRIFFON: Actually I think for --
13 for POC it was a little different because we had
14 to only use final cases, but I think for the
15 parameter you're thinking about, and maybe even
16 for decade empl-- first employed we can ask NIOSH
17 to do a query against the entire database, 'cause
18 you've got that data in there as soon as a
19 claim's in. And it might be interesting just to
20 see the -- not necessarily that we'll sample
21 proportionately, but at least we'll know --

22 DR. ZIEMER: Well, let's make this
23 point, that -- there's two ways to approach this.

24 One is to do the whole random sample, in
25 advance, of all the cases. Then once they're

1 settled, plug them in.

2 The other is to use the pool of final
3 cases and sample as you go. If you sample as you
4 go, then you can sort by POC if you wish, 'cause
5 you have that as a variable. But if you do a
6 pure random on all cases submitted, you do not
7 know the POC on --

8 MR. GRIFFON: No, my -- my point was
9 just to -- not -- not -- I don't disagree with
10 what you said, Paul. I was talking about another
11 thing, which was --

12 DR. ZIEMER: Oh.

13 MR. GRIFFON: -- to -- to define our
14 categories up front a little better --

15 DR. ZIEMER: Oh.

16 MR. GRIFFON: -- if we look at the whole
17 cohort statistics, and I didn't think about that
18 before, but we could -- we could ask to see
19 decade first employed for all, how many -- 30,000
20 cases or whatever you've got in the system, and
21 the same with years worked. I don't think that
22 would be hard to do, would it, Larry?

23 MR. ELLIOTT: No.

24 MR. GRIFFON: Then we could see how that
25 falls out and we can -- you know, we might make a

1 decision to sample proportionately for those, as
2 -- like we did for facility or we may say no, we
3 still want to know -- you know, but at least it'd
4 be interesting to see how they fall.

5 DR. MELIUS: Yeah, I would -- it seems
6 to me, and I can -- just what I know, that --
7 what's been settled so far and so forth is that I
8 think for efficiency purposes you're going to end
9 up having to first stratify on probability of
10 causation and sample within the categories here.

11 If not, I think it's -- I think it's going to be
12 hard to reach these --

13 DR. ZIEMER: Well, in fact some of these
14 may work against each other. For example, the --
15 if you go to a certain percent of short duration
16 work times, you may be heavily selecting from
17 AWEs, whereas you may want more samples from the
18 large facilities where the work times are longer.

19 So these could actually work against each other
20 if we're not careful.

21 I think Roy was next.

22 DR. DEHART: It's in part an extension
23 of what we were just talking about. We have
24 1,400 current cases out there, and I was just
25 going to ask how do we go about assigning a

1 number in selecting out of that? We assign a
2 number to all 1,400 and then how do we generate
3 what's coming out -- of cases that we're going to
4 see?

5 DR. ZIEMER: This proposal would use a
6 random number and select from those.

7 DR. DEHART: Okay. Based on the number
8 only, just as the random number is generated
9 initially.

10 DR. ZIEMER: Right.

11 MR. GRIFFON: That's it, yeah.

12 DR. DEHART: And that's going to have a
13 bias because the 1,400 cases are biased in where
14 they're coming from. We all know that.

15 DR. ZIEMER: That's understood, and that
16 sample base will change as time goes on.

17 DR. DEHART: I understand.

18 DR. ZIEMER: But the point is, though,
19 if we sample from that, it's still -- we're still
20 looking at a small total of what the eventual
21 matrix would be. And the idea here is we can
22 still fit these into our matrix.

23 And let me tell you that if the Board
24 approves this procedure today, we are prepared to
25 give you the list. I've not seen the list. It's

1 hidden in a mayonnaise jar, buried -- no.

2 UNIDENTIFIED: It's in the olive jar.

3 DR. ZIEMER: We asked Todd, who's the --
4 what's Todd's title? He's the information
5 management guy from NIOSH -- to generate the
6 random list for us in case the Board approved
7 this. We are prepared to give you a list of I
8 think 25, and we can look at that and say let's
9 take the first 20, and we're prepared to then
10 generate the disks and assign the Board members
11 and give that list to the --

12 MR. GRIFFON: (Inaudible)

13 DR. ZIEMER: -- to the contractor.

14 MR. GRIFFON: And just -- just --

15 DR. ZIEMER: Don't -- don't distribute
16 any copies, and -- no one has seen this list
17 except Todd.

18 MR. GRIFFON: Just so everyone
19 understands -- I mean that's the -- I mean we
20 just -- we ended up with a purely random up
21 front, generated a list with those descriptive
22 statistics, and then the --

23 DR. ZIEMER: The list will --

24 MR. GRIFFON: Our challenge will be to -

25 -

1 DR. ZIEMER: The list will tell you the
2 POC category, the facility --

3 MR. GRIFFON: Yeah.

4 DR. ZIEMER: It'll tell you all of
5 these.

6 MR. GRIFFON: And our challenge then is
7 to go down one by one through those 25 as a group
8 and just say in or out, and that's the hand
9 selection part of it. I think we -- we just felt
10 it -- especially at this first stage, we were
11 uncomfortable in -- you know, I think we're more
12 likely -- I was -- at least in the subcommittee
13 level, I was focused on let's -- let's fill the
14 matri-- let's worry about filling the matrix more
15 than having a purely random, stratified sampling
16 approach. We -- we can randomly select it
17 initially, but then we can hand-select them, we --
18 -- they're not identified cases so there's not --
19 we just have some descriptive statistics to help
20 us pick. And if -- you know, we know that
21 Bethlehem Steel, Savannah River, Hanford --
22 there's quite a few cases up front of those --
23 those three sites. If we end up with 20
24 Bethlehem Steels, we may say well, we don't want
25 to do 20 Bethlehem Steel lung cancers, you know.

1 So we can just X down some of those as we get
2 them, put them back in the pool, so to speak.

3 DR. DEHART: My question was one of
4 procedure, and I think I now understand what is
5 intended. I do have one other question and that
6 is the selection of the ten percent for the
7 forties employee group. It would seem to me that
8 you would want to be higher, because the
9 assumption on dose is going to be much higher in
10 that -- in that particular group. And I would
11 feel that there's perhaps a greater chance of
12 error and perhaps we'd want to see more of those
13 cases up front.

14 DR. ZIEMER: One of the things, though,
15 we're not sure of -- and we may have to get the
16 statistic -- is how many actual cases come out of
17 -- that still may be a smaller group 'cause
18 that's in the very early stages of things where
19 the system was building up in terms of numbers of
20 workers. I think our intuitive feeling was that
21 there were many more workers in the fifties.

22 DR. DEHART: (Off microphone) Oh, yes, I
23 would agree.

24 DR. ZIEMER: So that this kind of
25 reflects that, as well. But all of these can be

1 adjusted.

2 MR. ELLIOTT: Wanda.

3 DR. ZIEMER: Yes, Wanda.

4 MS. MUNN: Just a comment. To go back
5 to the potential of doing a purely informational
6 run just to see what's there right now, I guess I
7 would caution that the information that we've had
8 earlier today, and actually information that we
9 had comments in our minutes from last time, point
10 out that a very large percentage -- as a matter
11 of fact, what we have in the minutes is 49
12 percent of the claims that had been submitted
13 were non-covered claims. So if we were going to
14 do the kind of general information run that we
15 were talking about with respect to existing
16 claims...

17 MR. ELLIOTT: I think you're referring
18 to the Department of Labor's statistics --

19 MS. MUNN: Yes, I am.

20 MR. ELLIOTT: That's not in this
21 dataset.

22 MS. MUNN: Yes, I am.

23 MR. ELLIOTT: That's not in this
24 dataset.

25 MS. MUNN: Okay.

1 MR. ELLIOTT: The dataset --

2 DR. ZIEMER: These are only the NIOSH --

3 MR. ELLIOTT: The dataset that -- that
4 you would be talking about selecting from would
5 be the 15,000 -- or the 17,500 claims we have
6 right now that have not been -- that weren't
7 pulled back by DOL because they weren't a covered
8 cancer --

9 MS. MUNN: Yeah, okay.

10 MR. ELLIOTT: -- i.e., like lymphocytic
11 leukemia. So -- and of that, there's a subset
12 that we have sampled the 25 from, the list that
13 Dr. Ziemer's talking about that we have prepared
14 for you upon your -- the subcommittee's request,
15 that 25 sample was -- was randomly selected from
16 the 1,450-some, I don't know the exact number,
17 but...

18 MS. MUNN: No, I don't have any problem
19 with -- with the process that's going on for what
20 I consider this pilot run now.

21 DR. ZIEMER: Other questions? Yes,
22 Henry.

23 DR. ANDERSON: Yeah, I just wanted to
24 say what we -- when we talked about the
25 statistics, what we really meant is univariant

1 statistics, so that when we get through the 20
2 and we would come back to the Board, we'd tell
3 the public we reviewed four cases from Hanford,
4 but it would not be four cases from the 1940's,
5 from the what -- you know, that -- which would
6 get toward it, but we would say there were five
7 from the 1940's in the mix, there were three lung
8 cancers, two whatever's, but it wouldn't be lung
9 cancers from a site, so it would -- it's all
10 univariant so people will understand. One will
11 get a sense of what we're looking at from our
12 matrix, but it would not allow identifiers.

13 MS. MUNN: So summary findings is a
14 better --

15 DR. ANDERSON: Yeah.

16 MS. MUNN: -- appellation.

17 DR. ZIEMER: Let me make sure that we
18 have recorded the slight modifications. One is
19 to use the words "summary findings" rather than
20 "statistics" in item six. Another was to add --
21 and I didn't jot it down --

22 MR. GRIFFON: Yeah, I think you --

23 DR. ZIEMER: -- Wanda's -- what was it -

24 -

25 MR. GRIFFON: I think you could put it

1 at the end of paragraph three, something to the
2 effect of the following sentence: Once a case is
3 reviewed, it will no longer be available for
4 future sampling. Some -- something like that.

5 DR. ZIEMER: Yeah, that's --

6 MR. GRIFFON: Yeah.

7 DR. ZIEMER: Once a case is reviewed --
8 let's say it is removed from the sampling pool.

9 MR. GRIFFON: That's fine. That's
10 better.

11 DR. ZIEMER: Are those the only changes
12 in -- we've -- we'll take it by unanimous consent
13 that those are okay. Any other changes on any
14 parameters at the moment?

15 (No responses)

16 DR. ZIEMER: If not, I'm going to ask
17 for a vote on accepting these procedures. And
18 the understanding is in a sense these are
19 provisional, 'cause we're probably going to end
20 up modifying them as we gain experience.

21 Okay, all in favor, aye.

22 (Affirmative responses)

23 DR. ZIEMER: Any opposed?

24 (No responses)

25 DR. ZIEMER: Any abstentions?

1 (No responses)

2 DR. ZIEMER: Motion carries. Thank you
3 very much.

4 This is a motion -- because it comes
5 from the subcommittee, requires no second. Under
6 Robert's Rules, the report from the subcommittee
7 constitutes a motion but requires no second.

8 Now procedurally, what the subcommittee
9 is recommending is that if we select -- we're
10 recommending 20 cases for today. Because the
11 contractor's prepared to assign 20 cases at a
12 time, that will give them some experience.

13 MR. GRIFFON: I think that was our goal,
14 anyway. We were --

15 DR. ZIEMER: That was our goal.

16 MR. GRIFFON: -- depending on the
17 sampling.

18 DR. ZIEMER: We've asked the -- asked
19 Todd to give us a list of 25, so that if there's
20 -- if we see that there's, you know, a lot of
21 cases from some site that we think is over-
22 represented, we'd just bypass that and go on.
23 Hopefully we can select 20 cases.

24 And then what we're going to want to do
25 is -- the contractor will assign each case to one

1 of several persons on their team. We would like
2 to have two Board members on each case. And
3 obviously the conflict of interest thing comes
4 into play here, so if you've -- are working on a
5 site or have, then you can eliminate yourself
6 from being a reviewer. There would be a
7 timetable, and we're actually thinking about our
8 next meeting as a time when we could roll out the
9 first review of these cases, that the -- we would
10 rely on the contractor to look at these in depth
11 from a dosimetry point of view, but each of us
12 may have a perspective. And you will have the
13 full record. Every -- each Board member would
14 have a full record of their cases on disk, as
15 will the contractor. You'll have the opportunity
16 to interact with the contractor's team person.
17 And then prior to our meeting, we would have
18 working groups. A working group would be two
19 Board members and a contractor person that would
20 get together, come to a final agreement on a
21 recommendation to the Board for that particular
22 case.

23 Now the nature of the report is -- is
24 still not well-defined, other than it's -- we
25 know that it needs to be a general rollup, and

1 we're kind of learning it as we go here.

2 Okay, the list now is being distributed.

3 I do have a concern here that -- this list has
4 no identifiers on it in terms of code numbers of
5 case numbers. It does have decade, working years
6 and IREP model, which I suppose might in some
7 cases be -- someone might be able to use this to
8 identify an individual. Is that possible? But
9 at this point, whatever -- whatever comes out of
10 the review, it's not going to be linked to
11 specific cases, so here's the first 25. And
12 these were drawn at random. I'm just looking
13 down through this and I see -- one, two, three --

14 DR. ANDERSON: They're summarized.

15 DR. ZIEMER: Oh, all right. Okay. So
16 here's the frequency -- 32 percent of these cases
17 are Bethlehem Steel, 24 percent Savannah River,
18 12 percent Rocky Flats, and on down the line.
19 They've simply analyzed this for us. You see the
20 analysis by probability of causation.
21 Interestingly enough, none of them have fallen
22 between the 45 and 50, the area of great interest
23 to this group.

24 DR. ROESSLER: (Off microphone) Are
25 those mistakes, the 1930's?

1 MR. ELLIOTT: Can I make a --

2 DR. ROESSLER: (Off microphone) Are
3 those -- are those actual beginning dates?

4 MR. GRIFFON: (Off microphone) Decade
5 first worked --

6 DR. MELIUS: (Off microphone)
7 (Inaudible) worked at Bethlehem.

8 DR. ROESSLER: (Off microphone) There
9 are two of them from --

10 MR. PRESLEY: (Off microphone)
11 (Inaudible) see there may have been a --

12 DR. ZIEMER: Somebody may have started
13 working there before the actual -- that's their
14 date when they started working there, I think --
15 yeah. And then you see the various -- fair
16 distribution of kinds of cancers, and as you
17 might expect, the second category's probably
18 prostate.

19 MR. ELLIOTT: Let me make a comment on
20 the POC categorization here where there were --
21 none of the 25 showed up in that middle range of
22 44 or -- 45 to 49. There are only 20 cases in
23 that particular category anyway, so in this
24 random sampling, we didn't hit any one of those
25 20.

1 DR. ZIEMER: Now here's -- here's what
2 the Board can do. For example, if you said we
3 want at least one of those kind of cases in this
4 first run, then we can instruct Todd to go back
5 and select by POC and randomly select one of
6 those 20 cases. That's the kind of thing you can
7 do if you want to adjust the list and still keep
8 the randomness into it.

9 MR. ESPINOSA: (Off microphone) I'd say
10 we send Todd back.

11 DR. ZIEMER: But also keep in mind that
12 this is only 20 cases out of -- eventually we're
13 going to have hundreds of cases that we sample,
14 so this -- this is -- this is a kind of a first
15 run-through for us and for the contractor. This
16 is part of our learning experience on the
17 process.

18 MR. ELLIOTT: Let me restate -- I mis-
19 spoke. I stand corrected. Dr. Neton corrected
20 me. We have only eight cases that would be in
21 that category, between 45 and 49.9 percent. We
22 have 20 cases out of the first 4,000 that we have
23 turned over to DOL, so out of 1,450-some that
24 have reached the final decision stage, we have
25 only eight. So that's why --

1 MR. GRIFFON: That's a very small
2 number.

3 MR. ELLIOTT: We've got -- smaller than
4 20, even.

5 DR. ANDERSON: (Inaudible)

6 DR. ZIEMER: Well, and --

7 MR. ELLIOTT: My apologies.

8 DR. ZIEMER: -- for the initial run,
9 this may be fine because we're really learning
10 how to do the job.

11 DR. ANDERSON: We've got a lot of low
12 POCs.

13 MS. MUNN: We're all on the same
14 learning curve.

15 DR. ZIEMER: Which is fine.

16 MS. MUNN: That's fine. We have a few
17 high ones, too.

18 DR. ZIEMER: Now the -- what -- what I'm
19 going to ask for is -- to start us off, I'm going
20 to ask for a motion to accept the first 20 on the
21 list as the 20 that we will test --

22 MR. ESPINOSA: So moved.

23 DR. ZIEMER: -- and it's been moved and
24 --

25 DR. ANDERSON: Seconded.

1 DR. ZIEMER: -- and seconded. Was there
2 a second?

3 DR. ANDERSON: Seconded.

4 DR. ZIEMER: Now discussion. We can --
5 we can change that.

6 DR. MELIUS: I would just argue that
7 that gives us all the Bethlehem Steel and we end
8 up --

9 UNIDENTIFIED: (Off microphone)
10 (Inaudible)

11 DR. MELIUS: -- yeah, and whereas the
12 last five are not, and I'd rather eliminate five
13 of the Bethlehem Steel or something to that --
14 like that.

15 DR. ZIEMER: For now.

16 DR. MELIUS: For now, yeah.

17 DR. ZIEMER: And if we eliminate them,
18 they go back in the pool.

19 MR. GRIFFON: Right.

20 DR. ZIEMER: How many Bethlehem Steels
21 are you proposing we eliminate? And we will
22 eliminate them starting with the bottom of the
23 list, in fairness, I guess, and go up. There are
24 how many Bethlehem Steels?

25 DR. MELIUS: I just counted eight, I

1 think.

2 MR. ELLIOTT: (Off microphone) In our
3 frequency distribution (Inaudible).

4 DR. ZIEMER: There are eight Bethlehem
5 Steels.

6 MR. GRIFFON: (Off microphone) You have
7 to consider the other criteria, I would say -- I
8 would argue, but...

9 DR. ZIEMER: Jim is -- are you proposing
10 that we eliminate five Bethlehem Steels, Jim?

11 DR. MELIUS: Yeah.

12 DR. ZIEMER: And do you agree then that
13 it would be the last five on the list of
14 Bethlehem Steels? I mean we -- we just have --

15 DR. ROESSLER: We should look at
16 cancers, I think -- I think we should look at
17 other parameters. No?

18 DR. ZIEMER: I would argue that right
19 now it's too early to do that. If you're simply
20 sorting -- you're looking at facility as the
21 variable, then in -- in keeping with the process,
22 you just take them as they came. In other words,
23 you're saying well -- you've reached -- you've
24 saturated Bethlehem Steel with the third one.
25 The next one we draw, we eliminate.

1 DR. MELIUS: If we keep in mind --

2 MR. GRIFFON: Here's -- I'll make a more
3 specific proposal.

4 DR. ZIEMER: Okay.

5 MR. GRIFFON: I would propose to draw --

6 DR. ZIEMER: I'm sorry, I don't think we
7 had a second on your motion yet, but -- are you -
8 - are you re-motioning -- re-moving something?

9 DR. MELIUS: This may be a friendly
10 amendment.

11 MR. GRIFFON: Yeah, I think it's a -- I
12 think it's a friendly amendment. I still would
13 say five Bethlehem Steel cases, but I would say
14 let's drop number ten, 13, 14, 15 and 16 in the
15 order down the list that they appear. And I
16 looked at that based not only on Bethlehem Steel,
17 but also I didn't want to do like -- I think
18 there were a couple of colon cancers and a couple
19 of lung cancers, so --

20 DR. ZIEMER: Well, that's the last five
21 Bethlehem Steels.

22 MR. GRIFFON: Oh, is that the last five?

23 DR. ZIEMER: Basically that's --

24 MR. GRIFFON: So it's the same motion.

25 DR. ZIEMER: That's the same motion.

1 Did somebody second that motion?

2 MR. GRIFFON: I second Jim's motion.

3 DR. ZIEMER: Okay. The motion then is
4 to eliminate those five Bethlehem Steels and pick
5 up the last five on the list, and that's been
6 seconded. Is there discussion on this motion?
7 Robert, are you addressing the amendment?

8 MR. PRESLEY: No, I'll buy that.

9 DR. ZIEMER: Richard, addressing the
10 amendment?

11 MR. ESPINOSA: No, not addressing the
12 amendment.

13 DR. ZIEMER: We're addressing only the
14 amendment to drop five Bethlehem Steels. Yeah,
15 Tony?

16 DR. ANDRADE: Just one comment on the
17 next to the last Bethlehem Steel. Here we have a
18 really high POC, and then you have the lung
19 cancer situation, which is what we really kind of
20 expected. I think that that would be a very
21 interesting case to ring out.

22 MR. ESPINOSA: That's --

23 DR. ROESSLER: (Off microphone) There
24 are two of those, though.

25 MR. ESPINOSA: Yeah, there's one on --

1 DR. ROESSLER: (Off microphone)

2 (Inaudible) one is in the list.

3 MR. GRIFFON: Yeah, the first --

4 MR. ELLIOTT: Could we only talk one at
5 a time, please, for our recorder, who is a
6 champion, but he is somewhat disadvantaged when
7 he's got six people talking at once.

8 DR. ZIEMER: So Tony, are you speaking
9 against the motion to drop those five?

10 DR. ANDRADE: No -- okay. I recant. It
11 is pointed out to me there's another lung cancer
12 above it.

13 DR. ZIEMER: And again, keep in mind,
14 we're not filling the matrix with 20 samples.

15 MR. GRIFFON: I just want to make one --
16 one informational comment that I have --

17 DR. ZIEMER: Informational comment?
18 Yeah.

19 MR. GRIFFON: I have the matrix pulled
20 up, the proportional method that we proposed, and
21 I think Bethlehem Steel -- I don't know if this
22 is a current number, but I have 417 cases. So if
23 you just did -- there were 417 overall cases, so
24 I don't know -- you know, that's another argument
25 for -- not to sample too many --

1 DR. ZIEMER: Yes.

2 MR. GRIFFON: -- in this first round of
3 --

4 DR. ZIEMER: Thank you.

5 MR. GRIFFON: -- sampling from Bethlehem
6 Steel.

7 DR. ZIEMER: Thank you. See, this is
8 exactly the kind of run you'd like to get if you
9 were in Las Vegas. You're putting your money on
10 Bethlehem Steel. Right?

11 DR. ANDERSON: Right.

12 DR. ZIEMER: Okay. Are we ready to vote
13 on the motion to amend, which would be to
14 eliminate those last five Bethlehem Steels and
15 add the last five on the list, and that would
16 give us our list of 20?

17 All in favor, aye.

18 (Affirmative responses)

19 DR. ZIEMER: Any opposed, no?

20 (No responses)

21 DR. ZIEMER: Any abstentions? Let me --
22 I'm going to ask a question here. On doing this,
23 do Board members have to recluse (sic) themselves
24 if they're associated with one of these
25 facilities?

1 MR. ELLIOTT: Yes.

2 DR. ZIEMER: No, I think -- I think it's
3 an issue we have to --

4 MR. ELLIOTT: Yes. No, it is an issue
5 that you have to face. If -- I'll remind you of
6 your conflict of interest waivers. You have --
7 each of you -- may or may not -- have a waiver
8 letter, and in that waiver letter it will specify
9 what you must affirmatively recuse yourself on,
10 which site -- or sites. And I have a listing
11 here if it helps, if you don't remember what your
12 waiver letter says.

13 DR. ANDERSON: So did that --

14 DR. ZIEMER: Now --

15 DR. ANDERSON: -- (Inaudible) not have
16 voted on Bethlehem is the question.

17 DR. ZIEMER: Well, but you see, the
18 bigger issue is in voting on that you are also
19 voting to include some other sites. It's not --

20 MR. ELLIOTT: That is not a problem, I
21 do not believe. It's when you get into --

22 DR. ZIEMER: You're not really doing
23 anything with respect to evaluating it. It's
24 just the list of --

25 MR. PRESLEY: (Off microphone) Somebody

1 else could take that site.

2 MR. ELLIOTT: That's right. That's
3 right. You should recuse yourself if someone
4 wants to give you a site to review -- a case from
5 a site to review that you are -- your waiver
6 letter says you must recuse. This general kind
7 of voting I think is -- on -- on what to include
8 or exclude, is not a problem at this point.

9 DR. MELIUS: Just on the conflict of
10 interest issue, like for myself, I believe I
11 would have conflict, but it wouldn't be on any
12 parameter that would be available here. It
13 wouldn't be until I saw the case file.

14 DR. ZIEMER: Right.

15 DR. MELIUS: It would be an
16 occupational, I -- I don't think it's likely to
17 occur, but -- but it would be -- so -- so some of
18 that may be -- you know, like at least for me,
19 it's -- I won't know until I see the case.

20 MR. ELLIOTT: That is true, you wouldn't
21 know until you saw the case name.

22 DR. MELIUS: Right.

23 MR. ELLIOTT: The name of the
24 individual.

25 DR. MELIUS: And some more information,

1 in which case I think then -- then we have to
2 have a procedure for --

3 MR. ELLIOTT: Right.

4 DR. MELIUS: -- reassigning that case.

5 MR. ELLIOTT: That's -- yes, that's
6 correct.

7 DR. ZIEMER: Okay. We have now accepted
8 a list of 20 cases that will constitute the
9 initial review. I want to call on John Mauro to
10 describe for the Board how your team will handle
11 this, and then that will help them to understand
12 what we have to do.

13 MR. ELLIOTT: Can I verify for the
14 record who made that motion? I think Dr. DeHart
15 seconded it, but --

16 DR. ZIEMER: Well --

17 DR. MELIUS: I did.

18 DR. ZIEMER: -- we're going to attribute
19 it to Jim Melius.

20 MR. ELLIOTT: Okay. Now we stand
21 corrected.

22 DR. MAURO: Our proposal lays out
23 basically what I'll be summarizing, and our
24 proposal, as you folks probably know, is part of
25 the contract. So in essence, when the first set

1 of 20 cases come in, at that point I distribute -
2 - well, first and foremost, this issue of --
3 Privacy Act issue is critical 'cause I believe
4 these cases will have the identification.

5 DR. ZIEMER: Yes.

6 DR. MAURO: So first and foremost, we
7 have to make sure that we are all cleared from a
8 Privacy Act training perspective, and everyone
9 understands the seriousness of this. There will
10 be -- right now I anticipate -- we have
11 identified what I call case managers. These are
12 five very senior people, all of whom have some
13 specialty, expertise. They have many, many years
14 of experience, advanced degrees, but some of them
15 have more expertise in external, some more
16 internal, some really know an awful lot about
17 uranium or plutonium. We have five lead people
18 that I call case managers. Okay?

19 What I'm go-- what I -- my plans are to
20 distribute all the 20 cases to these five people,
21 in addition to distribute it to -- for some of
22 those -- some of those sites are currently in the
23 pipeline for site profile reviews, so for those
24 cases -- for example, as we all know, Bethlehem
25 Steel is the first one that looks like is going

1 to move through our pipeline for site profile
2 review, so by all means the task leader for
3 Bethlehem Steel will also receive the cases
4 dealing with Bethlehem Steel. Because what I'd
5 like to do is to make sure there's a linkage
6 between the case managers and the folks who are
7 leading the tasks regarding site profiles, so we
8 take advantage of the knowledge base that
9 currently exists within our team on Bethlehem
10 Steel, for example.

11 Okay, so let's -- let's say -- so -- so
12 on -- the first step in the process would be to
13 distribute the -- the C-- I assume -- they'll
14 come out in the form of CDs with -- with all the
15 records, would probably go out to on the order of
16 -- I would say perhaps eight or nine people
17 within our organization will get them all. Okay?

18 They'll all have probably a few days just to
19 scan through them -- okay? -- so they get an
20 appreciation for what the -- the nature of the
21 problem is. Then we're going to meet in McLean.

22 In the McLean meeting, it's at that point where
23 we're going to deal them out, so to speak. My
24 thinking is right now, each case manager will get
25 -- we have five case managers -- will get four

1 cases. Okay? Each person will get four cases.

2 We have our procedures. It's all laid
3 out in our proposal. We have an Appendix C to
4 our proposal, which is the procedures that we're
5 going to follow to perform these reviews. One of
6 the things that I'm starting to realize is that
7 those procedures are -- probably will -- are --
8 are a living document. That is, as we learn,
9 we're going to find out that they may be too
10 cumbersome. Because of the efficiency approaches
11 you folks have taken, it may not be necessary to
12 go through the -- but I'm getting adrift here.

13 So what happens is each person is going
14 to have a mandate. Each case manager will have a
15 mandate. This mandate will be to review that --
16 their -- his or her four cases within a certain
17 time period and with a certain work hour
18 allocation, so that they have a budget. And then
19 they're going to dive in.

20 Now they have the -- now within the work
21 hour budget they have, they can draw upon any one
22 of the 33 people that are on our team. That is,
23 we have a team -- team of 33 individuals, some of
24 which have very, very specialized expertise --
25 for example, in interpreting film badge

1 dosimetry. They can draw upon that expertise,
2 any expertise they care to, but within the
3 constraints of their work hours and the time
4 allotted to them.

5 When they're through, they're not going
6 to have a report but they will have their notes,
7 their findings and their -- their initial
8 perspective on the areas where there may be
9 strengths or weaknesses or problems with the
10 particular case. We will all reconvene -- let's
11 assume for now, for the time being, that we could
12 do that in one month. Okay? So on day one, we
13 -- we have this meeting where we deal out all
14 these cases. One month later, we all reconvene
15 back in McLean and each person will get up before
16 the rest of our team and tell their story
17 regarding each case and explain what they found
18 and their rationale for what they found. It'll
19 be discussed. I'm envisioning that -- for --
20 each person will require about a half a day, so
21 we probably would have a three-day meeting in
22 McLean of the team, go over all 20 and have a
23 chance to interact. Then each pers-- after that
24 interaction, each person would go back and write
25 his report regarding his findings, in light of

1 the discussions that were held. Once that report
2 is completed, it represents a draft report. At
3 that point that draft report will undergo our QA
4 process. We have a QA -- our QA -- you'll see
5 our QA procedure, make sure everything is signed
6 off as appropriate, and then it's delivered to
7 the Board.

8 Now I understand at some point in this
9 process the Board want-- you mentioned the Board
10 being involved where -- any place in the process
11 either the Board or NIOSH's folks certainly could
12 step in.

13 DR. ZIEMER: Let me describe what the
14 subcommittee was thinking about in that regard.
15 At the point that the team gets together in
16 McLean the second time, which is when you share
17 your information but you don't have a written
18 report, that for each case as it came up -- like
19 at 8:00 a.m. on a certain day, this case is going
20 to be discussed, and let's say that Mike and Tony
21 were the Board contacts, they would be on a
22 conference call with your team, have the
23 opportunity to feed comments in or -- and hear
24 your discussion. You're then going to develop a
25 written report for that case --

1 DR. MAURO: Yes.

2 DR. ZIEMER: -- and later, probably the
3 day before the Board meeting where we get
4 together, those two would meet with your team
5 person --

6 DR. MAURO: Okay.

7 DR. ZIEMER: -- for reviewing the final
8 report, and that would have to happen 20 times.
9 We have essentially ten Board members, so each of
10 our people are going to have several cases.
11 Let's see, how's that going to work out? We're
12 going to have five teams time-- we're going to
13 have four cases apiece, also. So any one of us
14 would have -- and in between would have the
15 opportunity to interact by -- and Leon, but --
16 12. And in be-- and because of conflict of
17 interest, things may be -- maybe not everyone
18 will have that same total cases, so we'll have to
19 divvy that up. But also have the opportunity to
20 e-mail your contact person if you have comments
21 to feed in in between.

22 DR. MAURO: Uh-huh.

23 DR. ZIEMER: And then the other thing
24 that will have to happen with all those cases is
25 the rollup, which will constitute the official

1 report, which is the public report which rolls up
2 all the cases into the summary -- whatever we
3 called that, statistics -- not statistics but the
4 summary findings, which is kind of a compilation
5 of all of that. That's how we're envisioning it.

6 Now -- so...

7 DR. MAURO: Could -- just logistically -
8 - so there is going to be -- that -- there's that
9 one month where we receive the documents. Okay?

10 We have everyone go through their review
11 process. Okay? Not quite sure whether it's
12 going to require a full month, or maybe it'll be
13 just a couple of weeks, so -- but we know what we
14 have here is -- what we really -- what I'm
15 hearing is what we have here is two-month
16 increments to deal with 20 cases. Basically over
17 that two-month period we want to go from the 20
18 cases arriving at SC&A to two months later being
19 in a position to give a pre-- to deliver hard
20 copy or electronic versions of our reports
21 regarding each case -- which of course would be
22 confidential -- and also prepare aggregate report
23 that would be appropriate for presentation before
24 the Board.

25 DR. ZIEMER: Right, the rollup.

1 DR. MAURO: And that all has to happen
2 over that two-month period. During that time
3 period there will be a lot of interaction between
4 our case managers and the two individuals that
5 would be assigned to each case, so there'd be a
6 very active dialogue there. Okay? That's --
7 that's fine, though. Okay.

8 DR. ZIEMER: That's how we're
9 envisioning it. Gen?

10 DR. ROESSLER: Do the Board members
11 involved get the CD at the same time that --

12 DR. ZIEMER: Yes. You will have the CD
13 -- you'll have the same body of information as
14 the person working it up, yes.

15 Robert?

16 MR. PRESLEY: Is that going to give you
17 enough time, if we all meet together the day
18 before the meeting, to roll up a final report?

19 DR. MAURO: Yeah, the logistics of this
20 is -- I'm not sure. I don't know -- I can't --
21 you know, this is...

22 MR. GRIFFON: (Off microphone) This is a
23 pilot (Inaudible).

24 DR. MAURO: Let's think about it. I
25 mean what do we have? Okay.

1 MR. ESPINOSA: (Off microphone)

2 (Inaudible) with conference calls and stuff.

3 MR. PRESLEY: Well, that's what I'm
4 wondering, if --

5 DR. ZIEMER: Don't all talk at once,
6 now. Robert, then --

7 MR. PRESLEY: That's what I'm wondering,
8 if we cannot make some decision on the four cases
9 that we've got sometime prior to that meeting and
10 say okay, you know, we either agree or we
11 disagree, or here's our findings that we don't
12 agree with, so that when we come back to the
13 meeting, a lot of this is going to be done.

14 DR. MAURO: I would suggest that once we
15 have our internal draft report, we say okay, I
16 think we have -- you know, we have our orals, the
17 orals, and you'll be listening to the orals --

18 MR. GRIFFON: Right, right.

19 DR. MAURO: -- so you okay, so you'll
20 get your first sense of where we're coming at,
21 and we'll calibrate at that point. You'll be at
22 least at a point that -- where we get some
23 feedback, are we seeing the monster the same way,
24 are we seeing the issues the same way. So
25 there's the first stage of calibration. That's

1 good. So that -- and we'll have a whole month in
2 front of us now. Okay? Or more, you know,
3 because -- or more. But I think what is
4 important, I hear what you're saying, is I think
5 we deliver our report in draft form to all 20 of
6 them a week before the meeting, so that gives us
7 -- 'cause the logistics of interaction and
8 refinement -- if we -- that would be the ideal
9 situation, if we could actually go from the oral
10 presentation, three weeks later have a draft
11 report that will go to you folks, and we have an
12 opportunity to discuss it, that would give us
13 time to -- especially this first time through. I
14 mean this is ideal. If we can do that, that -- I
15 think that would give us the time -- you're
16 absolu-- the day before will not work. You're
17 absolutely right, the day before will not work.

18 DR. ZIEMER: Okay, thank you. That's a
19 good point. And the -- the day before the
20 meeting -- I think as we envisioned it, the full
21 Board would be sitting there in terms of various
22 working groups. But it now becomes a full Board
23 session -- closed session 'cause we're dealing
24 with cases -- where each team would present their
25 findings and you would have already seen what

1 your particular cases involved, and we would have
2 an opportunity to look at the draft rollup at
3 that time and consider that, as a full Board.

4 MR. GRIFFON: One question I had on the
5 -- you know, we would have the CDs and access to
6 the -- Larry said the same information that the
7 contractor would. One exception I've been
8 thinking about since the presentation yesterday
9 was the reference database, and I wonder if
10 there's any way that the Board can get the same
11 access that the contractor has to NIOSH's
12 reference database. Because if we read through
13 these dose reconstructions and they reference
14 certain documents that we don't have -- I suppose
15 we could go through this process of requesting
16 them, but if they're all in this database, it
17 might be a lot more efficient if we had the same
18 access that SCA has. I don't know what that
19 involves, but if that's possible, I think that'd
20 be helpful.

21 MR. ELLIOTT: I certainly agree it'd be
22 helpful. I'm not sure how we've got it arranged
23 to give access to -- to you. John, have you --
24 Jim -- Jim's not in the room right now. I would
25 need his input on this.

1 DR. ZIEMER: We can follow up on that
2 and --

3 MR. ELLIOTT: But let me offer -- I'm a
4 little bit lost here on the dialogue between Bob
5 and John. The full Board can't meet as a full
6 Board on a conference call. That's a full Board
7 meeting.

8 DR. ZIEMER: No, no. No. No, this is -
9 - this -- the conference calls are only
10 individual team members with their contact.
11 We're talking about a full Board meeting the day
12 -- a closed Board meeting the day before the two
13 -- the regular open meeting where we would hear
14 all of the cases --

15 MR. ELLIOTT: Understood. Understood.

16 DR. ZIEMER: In other words Bob would
17 say -- Bob would present his four cases and their
18 findings --

19 MR. ELLIOTT: In order for us to effect
20 a closed meeting, we need to understand how much
21 time you want and what -- and we have to state a
22 purpose for that, which I think we know for sure
23 what that purpose is, but the time element is a
24 little bit nebulous to me right now, so if you
25 want a full day, that's what we'll -- we'll ask

1 for and get. If you want a half a day, that's
2 what we'll ask for and get. So --

3 DR. ZIEMER: We're talking about I think
4 hearing 20 ca-- no, this -- this becomes the full
5 Board, not the subcommittee. This becomes the
6 full Board to hear the cases summarized. 'Cause
7 we're all going to present to each other the
8 cases that we're responsible for. The contractor
9 would be there --

10 MR. GRIFFON: To hear -- to hear the
11 cases, and then I suppose also the --

12 DR. ZIEMER: And the findings --

13 MR. GRIFFON: -- summary -- and the
14 summary rollup --

15 DR. ZIEMER: -- and the draft summary --

16 MR. GRIFFON: Right, right, I think we -
17 -

18 DR. ZIEMER: And then the draft summary
19 could be brought -- well, would be brought to the
20 open meeting.

21 MR. ELLIOTT: The draft summary, if it's
22 prepared in time, could be sent to each of you as
23 a pre-decisional, deliberative document that you
24 would be required not to share with -- you know,
25 but you could at least get your eyes on it before

1 you came together in a group, in a meeting.

2 DR. ZIEMER: Gen Roessler and then
3 Robert.

4 DR. ROESSLER: On the mechanics of
5 receiving these CDs and receiving these reports,
6 which are all confidential, I'm trying to figure
7 out how they're going to arrive and how we're
8 going to handle it if we're on travel or
9 something when they arrive.

10 MR. ELLIOTT: Next week we will prepare
11 the CDs for you and send them out, so we need to
12 know where you want those delivered to, and we
13 will Fed Ex them to you. So -- and I was just
14 reminded that the Fed Ex package will be marked
15 confidential and to be opened only by you. These
16 won't -- the other way we can do it is registered
17 mail, but I'm more confident that Fed Ex is the
18 way to go.

19 DR. ZIEMER: Robert?

20 MR. PRESLEY: The only problem that I
21 see with this is -- is that we will have to make
22 sure that when you have your review where we call
23 in is that -- I presume you're going to do that
24 in three days. We could -- and it'll all be the
25 same conference call number -- that we recuse

1 ourself to make sure that -- like myself -- I
2 don't listen in on anything that I shouldn't be
3 listening in on.

4 MR. ELLIOTT: I think you're going to
5 have to coord-- this is a logistical nightmare
6 for your contractor to coordinate the conference
7 calls with the appropriate members on the
8 appropriate cases. Otherwise, you can't just
9 call in and sit and listen.

10 DR. ZIEMER: He's going to have to have
11 a list of who the team members are for each case.
12 When that case is ready, they probably will call
13 from your end --

14 MR. ELLIOTT: And it won't be the other
15 members of the Board.

16 DR. MAURO: There is a logistics problem
17 because you see, we're going to sort -- think of
18 it like this. It'll be a person. He'll be a
19 case manager. He'll have four cases. Some of
20 those cases -- say in your case -- might be
21 perfectly appropriate for you to sit in on that
22 two-hour, three-hour -- but some of them, you may
23 not. So what we will do is -- I think it's
24 important on our part to understand fully -- you
25 know, that is -- case manager number one has

1 these four cases. He's -- at this time period on
2 this day, he's going to give a presentation
3 before our crew on those four cases. You will
4 certainly be informed of that, and then you'll be
5 in a position to have -- you know, to alert us.
6 When we're ready to move on to the next case, the
7 problem then becomes if you'll have to recuse
8 yourself from that one -- we're talking about --
9 that means someone else would have to come in.

10 DR. ZIEMER: Right.

11 DR. MAURO: And you need to know -- you
12 all need to know our plans well in advance so
13 that you -- we could work this out. This is a
14 tough nut.

15 DR. ZIEMER: Right.

16 DR. MAURO: So -- but, yeah. But we'll
17 give you that information. We'll give you that
18 information.

19 DR. ZIEMER: I want to throw one other
20 thing into the hopper. Thank you, John. We
21 appreciate that; it's very helpful.

22 One other thing in the hopper is that we
23 have proceeded on the assumption that these are
24 20 basic reviews. The Board has the option of
25 saying that we want to do some advanced reviews,

1 although my recommendation is this first time
2 around we might be better just to do this, learn
3 the process, before we get into advanced reviews
4 -- unless anyone thinks that we should do an
5 advanced review this time around. Yes, Henry?

6 DR. ANDERSON: I thought at the
7 subcommittee meeting we discussed that we start
8 them all out as basic, and then at the verbal
9 discussion it may say this is, you know -- we
10 would then select some of those, rather than
11 randomly select for in-depth review. I mean that
12 was one way to go about it.

13 DR. ZIEMER: Right, and we had some
14 discussion as to whether or not you'd want to do
15 a random selection on advanced reviews or if you
16 want to pick a case. You can argue either way.
17 I was arguing for -- for not sort of prejudging
18 which ones would be the advanced reviews based on
19 what you find, but you can argue both ways. But
20 anyway, I think for this round, unless there's
21 strong sentiment otherwise, we'll consider these
22 as 20 basic reviews. We learn the process, the
23 contractor learns the process. We're getting up
24 to speed, as it were. Is that -- any objections
25 to that?

1 Rich, you have a comment?

2 MR. ESPINOSA: Not a comment, just a
3 question. I was just kind of wondering how the
4 teams'll be selected.

5 DR. ZIEMER: We're going to do that in a
6 few minutes. That is -- to some extent, there'll
7 be a self-selection process 'cause you know the
8 ones that you can't be on, if any, and -- and we
9 start looking for volunteers and see how things
10 proceed.

11 Roy?

12 DR. DEHART: For convenience, can we
13 just number these sequentially, so we can have
14 one, two, three, four -- and how do we identify
15 them otherwise?

16 DR. ZIEMER: I'm going to -- I'm going
17 to tell you you can unofficially number them, but
18 I've been told that we are not to associate any
19 identification numbers with cases. So we don't
20 want to refer -- can --

21 MR. GRIFFON: (Off microphone) Why not?

22 DR. ZIEMER: We'll get to --

23 MS. HOMOKI-TITUS: You can unofficially
24 number them to assist you in your process, and
25 then once you sort them, NIOSH will send you --

1 DR. ZIEMER: Some sort of number.

2 MS. HOMOKI-TITUS: -- some sort of --
3 they'll be identified when they're sent to you.

4 DR. ZIEMER: There will be -- there will
5 be a number to link it to a case number,
6 eventually. But in the open meeting we cannot
7 have a linkable number, so these are not numbered
8 right now. But for convenience, we can call
9 these one through 20.

10 DR. MELIUS: But going forward, there
11 will be a --

12 DR. ZIEMER: There will be a specific
13 number. Pardon me?

14 MR. GRIFFON: I'm just -- I don't know
15 if this is going to be an issue down the line. I
16 think it would be easier just to have the
17 linkable number. I mean you think of the CEDR
18 database, everything in there has a CER ID
19 number, which is linked back to a file --

20 MR. ELLIOTT: We could --

21 MR. GRIFFON: -- that's only held at --
22 and that's public domain.

23 MR. ELLIOTT: You could -- you saw this
24 earlier where on the previous runs Todd did for
25 you he had A-1 --

1 MR. GRIFFON: Right, right, right.

2 MR. ELLIOTT: -- B-1, we --

3 MR. GRIFFON: That's what I'm saying,
4 that would be --

5 MR. ELLIOTT: -- could do that here. We
6 can just assign these a number. He probably
7 already has them assigned an identifier where we
8 can key back to the claim number.

9 MR. GRIFFON: My argument is, why don't
10 -- if we had that on the -- on the sheet right
11 here in front of us, then the number we assign
12 would be the number -- you know, there'd be no
13 confusion.

14 MR. ELLIOTT: Fine, fine. Todd, do you
15 know what your numbering system is?

16 MR. GRIFFON: I don't -- Liz might
17 disagree with me, though. We had this discussion
18 --

19 MS. HOMOKI-TITUS: I'm sorry, I do
20 disagree with you. I realize that there's
21 another database out there that is numbered that
22 way, but it probably shouldn't be, and I can't
23 allow you guys to violate -- I'm not going to
24 advise you to violate the Privacy Act in that
25 manner. Like I said, you can informally number

1 these one through 20 so that they're --

2 DR. ZIEMER: Right now it's just --

3 MS. HOMOKI-TITUS: -- convenient for you
4 to use --

5 DR. ZIEMER: -- for assigning, it would
6 be one through 20.

7 MR. GRIFFON: (Off microphone) Okay, I'm
8 not going to (Inaudible).

9 DR. ZIEMER: Just do it sequentially.

10 MR. ELLIOTT: You assign a number, we'll
11 have the key. Okay? It's six of one, half a
12 dozen of another I think, in my mind, but just so
13 everybody here is clear, you need to have a PC
14 that will handle a compact disk that will open up
15 PDF HTML files. Okay? I hope everybody --
16 that's universal, I think, pretty much standard
17 now. We will work with you on getting you access
18 to our database systems that you heard about
19 yesterday that ORAU has. We're going to have to
20 figure out how best to do that. You're probably
21 going to have to load what we call CITRX on your
22 computers in order to access that database,
23 either through our system or -- probably it'll be
24 through the ORAU system, but we're going to have
25 to work on that with you --

1 DR. ZIEMER: Wanda, did you --

2 MR. ELLIOTT: -- individually.

3 DR. ZIEMER: Wanda?

4 MS. MUNN: I was going to suggest that
5 if our contractor could group the cases that his
6 people were going to look at in such a way that
7 they -- they obviously would themselves be people
8 who did not have to recuse themselves from those
9 sites. Then if they knew the sites we needed to
10 be recused from, it would be simpler for both
11 them and for us to match the fact that these
12 people cannot look at these sites, these people
13 cannot look at those. It would be simpler in the
14 long run. It would be difficult, I think, at the
15 outset to set that up, but it should be easy for
16 us to identify which sites we must recuse
17 ourselves from.

18 The other question that I had is -- and
19 when we finish the rollup of the summary
20 findings, who is going to present them to the
21 Board?

22 DR. ZIEMER: We didn't get that far.

23 MS. MUNN: Well, if we're going to do it
24 (Inaudible).

25 DR. ZIEMER: This is an audit that is

1 coming -- this is a report that is coming from
2 our contractor, I think, to the Board. We will
3 have seen it, but my -- my inclination is that
4 the contractor presents their summary and the
5 Board then takes action on it. That's how I
6 would see it, unless others see it in some
7 different way -- unless you're volunteering to
8 present it to us, Wanda.

9 MS. MUNN: No, thank you. I'm willing
10 to recuse myself.

11 DR. ZIEMER: One other related thing
12 I'll just throw into the mix here to make sure we
13 cover the bases. The IMBA material that some
14 have requested I believe is now available --
15 Larry, can you --

16 MR. ELLIOTT: You ready to hand that
17 out?

18 DR. ZIEMER: You want to speak to that
19 and tell us the status of that?

20 MR. ELLIOTT: We are ready to hand out
21 IMBA. You will each receive a disk with your
22 name on it. Your contractor will have a disk
23 that they can load on their intranet for their
24 use. I will also ask you to sign a non-
25 disclosure statement at this point in time. You

1 should be aware that this disk has coded language
2 in it so that if in fact you did share it with
3 somebody, we can trace it back to your disk, and
4 this is part of the agreement, the end-user's
5 license agreement that we had to negotiate with
6 the NRPB.

7 I also think you need to discuss a
8 training session.

9 MR. PRESLEY: (Off microphone) Yes.

10 DR. ZIEMER: Larry, you're specifically
11 talking about an IMBA training session -- or a
12 more general one, or both?

13 MR. ELLIOTT: Well, I think IMBA first,
14 but -- I don't know. Perhaps a training session
15 overall. I don't know how you feel about this,
16 but IMBA is a -- the biological models themselves
17 are complicated. The engine that runs it, you
18 know, takes -- is fairly intuitive, but it does
19 take, you know, a little bit of guidance and
20 walk-through just to make sure that you're
21 familiar with it and understand what features it
22 has and how it can do work for you. So -- and we
23 -- I would -- I would suggest -- I would offer
24 that our contractor, ORAU, has a -- an approved
25 set of tutorial procedures on IMBA that has been

1 used across all of their dose reconstructors.
2 And if you want to avail yourselves of those
3 procedures, we'll make those available to you.
4 It will provide at least some consistency in
5 approach. It will also give you some insight I
6 think into the type of training procedures that
7 ORAU has developed in this particular situation
8 with IMBA.

9 DR. ZIEMER: So would that -- would that
10 serve the purpose then -- in other words, this
11 could be done without going to Cincinnati or
12 something like that? Rich is shaking his head
13 yes.

14 MR. ELLIOTT: Dick, would you like to
15 come up and speak to that, as to how you see that
16 working?

17 DR. ZIEMER: While Dick finishes chewing
18 whatever he's eating, let me ask if -- if we can
19 get a copy of this for each Board member, it
20 doesn't have to be the signed copy, but once I
21 give this back, I don't remember what I agreed
22 to.

23 MR. ELLIOTT: Oh, yes, we will --

24 MS. HOMOKI-TITUS: Once you all sign it,
25 we'll make copies for each of you.

1 DR. ZIEMER: Okay, thank you.

2 DR. ANDERSON: (Off microphone) Yeah,
3 but it --

4 MR. ELLIOTT: Please speak into the
5 mike.

6 DR. ANDERSON: The question is, it says
7 here we have to register, and how do we do that?

8 MS. HOMOKI-TITUS: I believe that the
9 way you do that is through the software. Just
10 like any other software that you received from
11 Microsoft, I believe it'll lead you --

12 DR. ZIEMER: Lead you through it.

13 MS. HOMOKI-TITUS: -- possibly will --
14 does it lead you to a web site where you
15 register?

16 DR. NETON: (Off microphone) No.

17 MS. HOMOKI-TITUS: No.

18 DR. NETON: (Off microphone) I'm sorry -
19 -

20 MS. HOMOKI-TITUS: Okay, Jim's going to
21 explain that then.

22 DR. NETON: I'm sorry, I got taken away
23 for a second. Where are we at?

24 MR. ELLIOTT: We have issued IMBA and
25 the question on the table is once they sign the

1 disclosure form, how do they register?

2 DR. NETON: Right. That'll -- that'll
3 be -- that'll take place at the time that the
4 EULA is issued, the end user license agreement,
5 which is still in process. So any -- any
6 notations in there that talk about signing the
7 end user license agreement -- I think it says
8 pursuant to the agreement. Well, the agreement
9 has not been finalized yet, so this is a
10 conditional sort of usage until you sign the
11 ultimate end user license agreement. At that
12 point it'll become clear as to how to register it
13 with -- with ACJ* & Associates.

14 DR. ZIEMER: So there'll be something
15 else that --

16 DR. NETON: There'll be an additional
17 requirement for you to sign the contents or the -
18 - agree with the conditions of the end user
19 license agreement. This is an interim usage we
20 worked out with ACJ & Associates where the Board
21 is authorized to use it fully under the
22 conditions that are in that piece of paper you
23 have now, and there will be more paperwork to
24 come. That's about all I can tell you.

25 We have also made --

1 DR. ANDERSON: I mean that's not --
2 that's not what we're signing.

3 DR. NETON: It's not what you're
4 signing.

5 DR. ANDERSON: No.

6 DR. NETON: You're not signing the end
7 user license agreement.

8 DR. ANDERSON: No, it says we have to do
9 it, and then it also says we're required to
10 register, and --

11 DR. NETON: Right.

12 DR. ANDERSON: You know, and then it
13 says if we're in violation -- I mean it's a legal
14 document that I'm agreeing to register, and I
15 want to -- I want to register now for whatever
16 I'm supposed to --

17 DR. ZIEMER: Well, it doesn't say when
18 you have to do that, it says --

19 DR. ANDERSON: No, but...

20 DR. NETON: This is --

21 DR. ZIEMER: It's a little like fishing,
22 you got to do it before you get caught.

23 DR. NETON: -- (Inaudible) issues and I
24 can't speak to that. (Off microphone) Maybe we
25 could put out some (Inaudible).

1 MS. HOMOKI-TITUS: Since it doesn't give
2 you a limitation on when you must do this, I'm
3 going on the record and telling you that you
4 don't have to register it until we have a EULA.
5 You'll have access to a copy of the EULA. This
6 is just a preliminary -- we wanted to try to get
7 this to the Board so it's the best we could come
8 up with to try to protect the software
9 manufacturer and us and you all. So there'll be
10 a new agreement once the EULA's finalized.

11 MR. ELLIOTT: We don't expect the EULA
12 to change based upon its content at this point in
13 time. The problem here is that we're dealing
14 with the NRPB and in -- in England right now, and
15 we had some language inserted into the EULA about
16 the U.S. Federal Acquisition Record -- or Regist-
17 - what is it, Register --

18 DR. NETON: Federal Acquisition
19 Regulations, a FAR.

20 MR. ELLIOTT: -- Regulations, and
21 they're not familiar with it. And they're also
22 on vacation during the month of August, and so
23 that's been part of the difficulty in getting
24 this put into place.

25 DR. ANDERSON: You know, I'm -- I'm just

1 saying that as a legal document, it says I will,
2 in accordance with the terms set forth in the end
3 user license agreement --

4 DR. NETON: I think it's pursuant --
5 pursuant to the terms or something like that. I
6 mean there's --

7 DR. ANDERSON: No, in accordance with
8 the terms set forth --

9 DR. NETON: I understand pursuant to the
10 EULA I am required to register, so there is no
11 EULA --

12 DR. ANDERSON: No, no, number three I'm
13 looking at now.

14 DR. NETON: Okay.

15 DR. ANDERSON: I don't know what the
16 terms are, so how can I follow them if I haven't
17 seen the EULA --

18 DR. ZIEMER: Your intent is to follow
19 them and --

20 DR. ANDERSON: Yeah, well, I --

21 DR. ZIEMER: I would -- I --

22 MS. HOMOKI-TITUS: Right, this is your
23 intent to follow them, and we -- as soon as the
24 EULA is agreed to, we'll provide you a copy of
25 it.

1 DR. ANDERSON: I mean --

2 DR. ZIEMER: But you know, if --

3 MS. HOMOKI-TITUS: Basically what you're
4 agreeing --

5 DR. ANDERSON: I'm just saying --

6 DR. ZIEMER: But if you're hesitant --

7 DR. ANDERSON: -- as a legal document --

8 MS. HOMOKI-TITUS: If you're hesitant,
9 we can pull the document back and take your
10 software back.

11 DR. ZIEMER: -- just -- we can wait, but
12 give back the disk.

13 MS. HOMOKI-TITUS: That's the best that
14 we can do at this point.

15 DR. ANDERSON: Okay.

16 DR. ZIEMER: Gen Roessler has a
17 question.

18 MR. ELLIOTT: Would it be helpful if you
19 summarize what's in the EULA as we understand it
20 now?

21 DR. ANDERSON: Yeah, that would be
22 helpful.

23 DR. NETON: The conditions -- to my
24 knowledge, the conditions of the end user license
25 agreement are very similar to what you're looking

1 at here as far as non-disclosure and those type
2 of issues -- sole use for -- on this project.
3 That's -- it's standard -- it's standard license
4 agreement -- no different that -- well, I won't
5 say no different, but very similar to what you do
6 when you got an Excel spreadsheet product from
7 Microsoft, I will only use this for my own
8 purposes or the conditions for which it was
9 purchased, that kind of stuff. I mean there's no
10 real surprises there. It's just that we're
11 dealing with a foreign country's regulations
12 versus ours.

13 DR. ZIEMER: Gen Roessler has a comment
14 or question.

15 DR. ROESSLER: Well, this may be a
16 detail, but I think it's an important one. The
17 thing I'm going to sign says it's version 3.1.
18 It says that in several places. The disk I got
19 says version 3.2.03.

20 DR. NETON: Okay, that -- I think -- Liz
21 can concur, I hope, that if you initial and date
22 --

23 DR. ROESSLER: Can we just cross it out?

24 DR. ANDERSON: Oh, good.

25 DR. NETON: -- put the -- put the right

1 version there and initial and date it, I think
2 we'll accept that.

3 MR. PRESLEY: Question.

4 DR. ZIEMER: Robert?

5 MR. PRESLEY: When I leave here, I'm
6 going to leave the country for three or four
7 days, and all of the -- all of my luggage and
8 everything like that's subject to be searched.
9 Should I let you all go ahead and send this to my
10 house?

11 MS. HOMOKI-TITUS: Yeah, we can do that.

12 DR. NETON: We can send that to your
13 home. That's not a problem.

14 MR. PRESLEY: I don't know, but it's --
15 you never know.

16 DR. NETON: One thing that I will
17 caution you is if you notice in small print on
18 the cover, your name is embossed, so it is
19 actually registered to you -- not on the cover,
20 but on the disk itself, it is licensed to you.
21 And I've been told by the vendor, and this is not
22 specially put in there for the -- by the Board --
23 or for the Board, but they can track who it's
24 licensed to if copies of printouts end up
25 circulating about with other users, that sort of

1 thing -- just to point out that that feature is
2 part of the software.

3 MR. ELLIOTT: I already did.

4 DR. NETON: Oh, I'm sorry, I missed
5 that.

6 DR. ZIEMER: Wanda.

7 DR. NETON: I'm being redundant here.

8 MS. MUNN: An easy question, I think.
9 The description identifies 256 megabytes of RAM
10 recommended. How much does it actually take up,
11 how much space -- disk space, do you know?

12 DR. NETON: I have no idea. Oh, that's
13 not disk space, that's RAM, so that would be
14 memory.

15 MS. MUNN: I shouldn't say disk. How
16 much memory?

17 DR. NETON: I think that might depend on
18 what you're running. If you're running the
19 thorium model, which has all kinds of daughter --
20 progeny, rather, it would take up more, but I
21 can't tell you.

22 MS. MUNN: Okay, that's fine.

23 DR. NETON: I think the specification
24 basically says if you run all the features and
25 you have 256 megabytes, it shouldn't crash. It

1 should run.

2 MS. MUNN: And everything else on my
3 system goes down.

4 DR. ZIEMER: Gen Roessler has a comment?

5 DR. ROESSLER: (Off microphone)
6 (Inaudible)

7 DR. ZIEMER: No comment? Rich, a
8 comment?

9 MR. ESPINOSA: I can see myself putting
10 this on pretty much every computer I use -- one
11 at the union hall, one at work, one at home and
12 one on my laptop, you know. Are there any legal
13 issues with that? I can imagine one being with
14 the union --

15 MR. ELLIOTT: You will need to make sure
16 and assure us that your -- each computer you load
17 this on is password-protected --

18 MR. ESPINOSA: Okay.

19 MR. ELLIOTT: -- and has a time out on
20 it. We'll have to send you all a copy of our --
21 I think you've already done this in some cases --
22 have they not done the SAFE -- if you come to our
23 offices, the last -- the working group session,
24 you had to go through SAFE, which is a training
25 session on how to protect your computer and

1 privacy information on your computer.

2 MS. HOMOKI-TITUS: The only thing I want
3 to be sure that you understand is if you put it
4 on all of those computers, you are the only one
5 who's allowed to use it.

6 MR. ESPINOSA: Yeah, I know.

7 MS. HOMOKI-TITUS: You -- as long as you
8 have a way of protecting it, if you put it on a
9 computer, then no else is going to be able to use
10 that program.

11 MR. ESPINOSA: More than likely I'll
12 just keep it on the laptop, but --

13 DR. NETON: (Off microphone) Yeah, I
14 would (Inaudible). That would be my
15 recommendation.

16 UNIDENTIFIED: (Off microphone) I think
17 that'd be -- you'd better be real smart, Rich.

18 DR. ZIEMER: Any other questions or
19 comments?

20 (No responses)

21 DR. ZIEMER: Do you wish to proceed and
22 select the teams at this point for --

23 MR. ELLIOTT: (Off microphone) Can we
24 have Dick speak to what you -- your question
25 earlier since he's (Inaudible)?

1 DR. ZIEMER: Oh, yeah. What was the
2 earlier question?

3 MR. PRESLEY: (Off microphone) Training.

4 DR. ZIEMER: Oh, training, yes. Dick?

5 DR. TOOHEY: Okay, very briefly, we've
6 got about half a dozen training modules that --
7 in the package for IMBA, and they start by just
8 walking you through the program. Then there's a
9 couple where you get a sample of bioassay data
10 and it walks you through entering that, running
11 the models. And then the final part is the test,
12 which gives you one or two sets of bioassay data
13 that you get to run yourself, and if you don't
14 get the right answer, you don't get to do dose
15 reconstruction under our policies. But we can
16 make that available to you, either what we've
17 done before, which is give you access to our
18 server, or as, you know, stand-alone modules or
19 whatever.

20 DR. ZIEMER: So it's self-tutorial.

21 Right?

22 DR. TOOHEY: Yes, it is. It's --

23 DR. ZIEMER: Wouldn't it be easier just
24 to --

25 DR. TOOHEY: -- set up for --

1 DR. ZIEMER: -- do a disk?

2 DR. TOOHEY: -- remote users.

3 DR. ZIEMER: Yeah.

4 MR. ELLIOTT: Could you just send them a
5 disk?

6 DR. TOOHEY: To the best of my knowledge
7 and belief, to coin a phrase, we can do that.
8 But you know, until I talk to my IT guys, I won't
9 guarantee it.

10 DR. ZIEMER: If you will, try to find a
11 way to get that training available to everybody.
12 GIBSON HAS LEFT THE BUILDING.

13 DR. NETON: I have one more -- Larry,
14 did you mention the fact that SC&A also is
15 receiving a copy of this for distribution?

16 MR. ELLIOTT: Yes, and then there was a
17 question that I attempted to answer with Todd's
18 assistance about getting the Board members
19 access, as we have given Sanford Cohen Associates
20 access, to the databases. Now we need to figure
21 out how to do that, whether it's through ORAU and
22 give each member of the Board CITRX -- I don't
23 know.

24 DR. NETON: No, this is a different
25 issue. If we're talking about the site research

1 database that I discussed yesterday, that would -
2 - that would go through ORAU. That's outside of
3 the firewall, and so I'm not sure how that -- how
4 did that come up in relation to IMBA? I guess I
5 missed --

6 DR. ZIEMER: No, not in relation to
7 IMBA.

8 MR. ELLIOTT: This is just in relation
9 to reviewing cases, how can they get access to
10 the documents that are relevant --

11 DR. MELIUS: (Off microphone) The
12 reference documents.

13 MR. ELLIOTT: -- the reference that are
14 considered relevant to the case.

15 DR. NETON: Fair enough. We'll have to
16 work with ORAU to -- this would require a VPN, I
17 believe -- a Virtual Private Network setup --
18 much like what was established with Sanford Cohen
19 & Associates, on each of your computers. And
20 there's also some Privacy Act training that's
21 mandatory under ORAU's policy.

22 DR. TOOHEY: (Off microphone) I'll waive
23 the Privacy --

24 DR. NETON: He'll waive the Privacy Act
25 for the Board. They've had several Privacy Act

1 training sessions. So -- but yeah, it is -- it
2 is technically doable. We'll just have to work
3 out the logistics -- through ORAU, though.

4 MR. ELLIOTT: So I want a commitment
5 that we're going to do that very quickly --
6 within the next -- can we say within the next two
7 weeks, we're not only going to deliver these
8 disks, we're going to deliver the IMBA training
9 modules, we're going to deliver whatever
10 mechanism we need to set up to allow them access
11 to the data.

12 DR. NETON: I will commit for Dick,
13 who's standing to my left here, let the record
14 show.

15 MR. ESPINOSA: It might be a good idea
16 to send out the confidentiality forms again.
17 I've lost mine, but I know what I'm excluded
18 from.

19 DR. ZIEMER: Which forms are you talking
20 about?

21 MR. ELLIOTT: I have the conflict of
22 interest sheet here for when you start your
23 selection right now. I think -- did we get Mike
24 Gibson's IMBA disk to him and get his non-
25 disclosure statement?

1 UNIDENTIFIED: (Off microphone) Yes.

2 MR. ELLIOTT: Okay. And so we need to
3 take care -- you know, in your selection, I can
4 address each of your individual conflicts if you
5 don't remember. If you also recall, every year
6 you have to go through a new conflict of interest
7 disclosure, filing an OGE 450 form and then that
8 will trigger a new waiver letter.

9 DR. ZIEMER: You should have gotten that
10 very recently 'cause this is the time of year
11 they do it, isn't it, or is it --

12 MR. ELLIOTT: Yes, it's ongoing right
13 now, and I will offer this, that there are
14 additional -- or new -- new sets of eyes looking
15 at these things and asking questions, and so
16 we're going through that process at this point in
17 time in the year. But you are to operate under
18 the current waiver letter that you have been
19 given. And if you have any questions about that,
20 I have a chart here that speaks to each
21 individual's -- Board member's conflict.

22 DR. ZIEMER: Okay. As far as the team
23 assignments, now, how do you wish to proceed? Do
24 you want to volunteer for certain ones or -- any
25 -- I think we can allow that, if we just go down

1 the list. We're going to need two individuals
2 for each case, and up to four cases per
3 individual.

4 DR. ANDERSON: I guess just from the
5 logistics of the phone call, it would seem if --
6 if we can have the same two people share four
7 cases --

8 DR. ZIEMER: That would be helpful --

9 DR. ANDERSON: -- rather than have --

10 DR. ZIEMER: -- it may not be always
11 possible, but --

12 DR. ANDERSON: -- all 20 of them be
13 different combinations of two.

14 MR. PRESLEY: (Off microphone)
15 (Inaudible) just two cases.

16 MR. GRIFFON: (Off microphone) Up to --
17 up -- yeah.

18 DR. ANDERSON: (Off microphone) Two --
19 two people per case.

20 DR. ZIEMER: Two per case for four
21 cases.

22 MS. MUNN: (Off microphone) Four cases.

23 DR. ANDERSON: (Off microphone) Yeah.

24 DR. ZIEMER: So for -- for example,
25 let's take the first four cases on the list.

1 What -- do we have two individuals that have no
2 conflict with any of those sites that want to do
3 those four?

4 MR. PRESLEY: (Off microphone) I don't
5 have any conflict (Inaudible).

6 DR. ZIEMER: I see we have quite a few.
7 So shall we -- just want to take these in order,
8 since -- I mean does anyone have a strong
9 preference, you're just -- okay. So why don't we
10 -- why don't we put Robert and Henry on the first
11 four cases; is that agreeable?

12 MR. PRESLEY: (Off microphone) That's
13 fine --

14 DR. ANDERSON: (Off microphone) Team A -
15 -

16 MR. PRESLEY: -- with me.

17 DR. ANDERSON: -- team A.

18 UNIDENTIFIED: (Off microphone) Way to
19 go, Robert.

20 DR. ZIEMER: Well, I'm not sure --

21 UNIDENTIFIED: (Off microphone) You're
22 out of the country.

23 MR. PRESLEY: (Off microphone) Yeah, but
24 you're not going to get anything for the next two
25 weeks.

1 DR. ZIEMER: Now we may have to shift
2 this --if we end up the last team with some
3 conflicts, we may have to -- okay, the next four
4 cases would be Savannah River, Bethlehem Steel,
5 Oak Ridge and again Savannah River. Tony and
6 Mark, are you okay on those?

7

8 MR. GRIFFON: (Off microphone) Yes.

9 DR. ZIEMER: The next four would be
10 Savannah River, Blockson, feed materials* and
11 Rocky Flats.

12 DR. ROESSLER: No, you missed --

13 DR. ZIEMER: Did I --

14 DR. ROESSLER: -- you missed nine.

15 UNIDENTIFIED: (Off microphone)

16 (Inaudible) Bethlehem.

17 DR. ROESSLER: Bethlehem.

18 DR. ZIEMER: Oh, another Bethlehem. I'm
19 sorry -- Savannah River, Bethlehem -- or
20 Blockson, Bethlehem and feed materials. Right?

21 MR. ELLIOTT: (Off microphone) Bethlehem
22 Steel, Savannah River, Blockson and (Inaudible).

23 DR. ZIEMER: Right. Gen and Roy? Okay.

24 Then we have Rocky Flats, Hanford, Savannah
25 River and Rocky Flats again. Jim?

1 DR. MELIUS: (Off microphone) I'm okay,
2 yeah.

3 DR. ZIEMER: Wanda?

4 MS. MUNN: (Off microphone) I can't do
5 Hanford.

6 DR. ZIEMER: Oh, we got Hanford in
7 there. Okay, I'll jump in.

8 MR. ESPINOSA: I could jump in on that
9 one.

10 DR. ZIEMER: Okay, we'll put Jim and
11 Rich. Then we have -- then we have Huntington,
12 Savannah River, Y-12 and feed materials.

13 MS. MUNN: (Off microphone) Yeah, I can
14 do that.

15 DR. ZIEMER: Now I've got a conflict
16 with Y-12, so I'm going to --

17 MR. GRIFFON: We've got Leon and Mike,
18 also.

19 DR. ZIEMER: I need to trade that.

20 UNIDENTIFIED: (Off microphone) Yeah,
21 you've got Leon and Mike.

22 MR. GRIFFON: I don't think either one
23 of those are conflicted for those four sites, are
24 they? I don't know.

25 MR. PRESLEY: (Off microphone) Larry can

1 look and see.

2 MS. MUNN: I'm fine with those.

3 MR. GRIFFON: (Off microphone) Wanda's
4 fine.

5 DR. ZIEMER: Do we have an odd number of
6 people?

7 MR. PRESLEY: Yeah.

8 DR. ZIEMER: Okay. Oh, this worked out
9 very well. The Chairman is (Inaudible).

10 MR. ELLIOTT: (Off microphone) You can
11 pick which one (Inaudible).

12 UNIDENTIFIED: (Off microphone) Wanda --

13 MS. MUNN: (Off microphone) I've got
14 Mike, do I?

15 MR. PRESLEY: (Off microphone) Wanda's -
16 -

17 DR. ZIEMER: Wanda --

18 MR. ELLIOTT: Neither Mike or Leon are
19 conflicted on those last four.

20 MR. GRIFFON: Can we say Wanda, Mike and
21 Leon, since we're going to have an extra person?

22 DR. ZIEMER: We've got two extras then.
23 We've done ten. We have -- Wanda and me are
24 left.

25 MR. ELLIOTT: (Off microphone) Or you

1 can give three cases to a couple of groups.

2 DR. ZIEMER: Yeah.

3 MR. ESPINOSA: (Off microphone) There
4 you go.

5 DR. ZIEMER: Maybe that's the way to do
6 it. Then we'll just lighten the load on a
7 couple.

8 (Pause)

9 DR. ZIEMER: This is very arbitrary.

10 MR. ESPINOSA: (Off microphone) Could
11 you do it by site?

12 DR. ZIEMER: How about if -- yeah, let's
13 -- would this be all right? Presley and Anderson
14 take the first three. Let's take -- let's take
15 the two Savannah Rivers --

16 MR. GRIFFON: Who's that for, the two
17 Savannah Rivers?

18 DR. ZIEMER: There are two in a row
19 there.

20 MS. MUNN: (Off microphone) Yes,
21 (Inaudible).

22 MR. ELLIOTT: (Off microphone) Two
23 Savannah Rivers and Bethlehem Steel.

24 DR. ZIEMER: And -- you know, I'd
25 skipped one anyway, hadn't I? Or no? Let's see

1 -- two Savannah Rivers and Bethlehem Steel, and
2 we'll give that to Wanda --

3 MR. ELLIOTT: (Off microphone) You had
4 Tony and Mark, so --

5 MR. GRIFFON: (Off microphone) Yeah,
6 we're already -- are you reassigning now?

7 MR. ELLIOTT: (Off microphone)
8 Reassigning now?

9 DR. ZIEMER: Wait a minute, who'd I have
10 there?

11 MR. ELLIOTT: You had Tony and Mark for
12 the next four.

13 DR. MELIUS: Henry, I'll trade you a
14 Savannah River for a Hanford.

15 DR. ZIEMER: I want to take one from
16 each of those teams and just move them down or
17 something. What's a way to do this?

18 (Pause)

19 MR. GRIFFON: (Off microphone) You could
20 have teams of three for these first cases, too.

21 DR. ZIEMER: That's what I'm -- that's
22 what I'm looking at.

23 MR. GRIFFON: (Off microphone)
24 (Inaudible) person on it instead of moving cases
25 around.

1 DR. ZIEMER: Well, I was going to have
2 three cases per team for -- instead of four cases
3 per team; it just lightens the load -- rather
4 than having more people on a case. So -- so what
5 I've got here is Presley and Anderson take the
6 first three cases -- here's an easy way to do it
7 -- then Andrade and Griffon take the next three,
8 which would be Savannah River, Savannah River,
9 Bethlehem -- is that all right? We just move you
10 up?

11 DR. ANDERSON: (Off microphone) Then
12 take the next three --

13 DR. ZIEMER: And then --

14 DR. ANDERSON: -- make it your
15 (Inaudible).

16 DR. ZIEMER: No, I can't be in the next
17 three 'cause there's an Oak Ridge there again.

18 DR. ANDERSON: Oh.

19 MR. GRIFFON: (Off microphone) I was
20 just looking at that.

21 (Pause)

22 DR. ZIEMER: So we'll just move Gen --
23 Gen and Roy up three. Are we still okay then?

24 MR. ELLIOTT: (Off microphone) Yep.

25 DR. ZIEMER: Oak Ridge, Savannah River,

1 Bethlehem?

2 DR. DEHART: (Off microphone) I can't do
3 Oak Ridge.

4 MR. ELLIOTT: (Off microphone) Oh,
5 that's right.

6 MR. GRIFFON: (Off microphone) You
7 should have left Tony and I with Oak Ridge.

8 DR. ZIEMER: Okay, let's switch you.
9 Let's -- let's put Roessler and DeHart for Rocky
10 -- or Savannah River, Savannah River, Bethlehem.
11 Is that better?

12 MR. GRIFFON: (Off microphone) Yeah.

13 DR. ROESSLER: (Off microphone) Okay, we
14 just --

15 DR. ZIEMER: Second -- second team -- or
16 second group will be Roessler and DeHart then.

17 MR. GRIFFON: (Off microphone) And then
18 we -- then Tony and I have the next (Inaudible).

19 DR. ZIEMER: Then we have Tony and Mark
20 the next three.

21 MR. GRIFFON: Which is -- just make sure
22 I'm on the right line, Paul, that's Oak Ridge,
23 Savannah River, Bethlehem?

24 DR. ZIEMER: Yes.

25 MR. GRIFFON: Okay.

1 DR. ZIEMER: Then -- then we can insert
2 -- does that give us -- that gives us three open
3 now. Does that give us Savannah River, Blockson
4 and feed materials. Right? Which will now be
5 Wanda and me. Are we okay?

6 MR. GRIFFON: Well, I was just -- I
7 didn't know if -- just to make a suggestion, I
8 don't know if it would make sense to have Mike
9 and -- and Leon split with you and Wanda just to
10 split the technical experti-- I don't --

11 DR. ZIEMER: Oh, sure, that's fine.
12 Let's -- let's -- if we have no conflict, we can
13 put Mike and me on -- that would be --

14 MR. GRIFFON: (Off microphone) Savannah,
15 Blockson and feed materials.

16 MR. ELLIOTT: (Off microphone) That's no
17 conflict.

18 DR. ZIEMER: That would be Savannah
19 River, Blockson and Fernald. Right?

20 MR. GRIFFON: (Off microphone) Right.

21 DR. ZIEMER: And then Wanda will be with
22 Mike (sic) on Savannah River, Y-12 and Fernald.

23 DR. ROESSLER: (Off microphone) You left
24 out --

25 MR. GRIFFON: (Off microphone) Didn't we

1 leave out Huntington?

2 MR. ESPINOSA: (Off microphone)

3 (Inaudible) Leon.

4 DR. ZIEMER: With Leon. Now let's go
5 through these again.

6 MR. GRIFFON: (Off microphone) Yeah,
7 read (Inaudible).

8 DR. ZIEMER: The first three are Presley
9 and Anderson.

10 MR. ELLIOTT: And can we -- can we
11 number these as we go, 'cause --

12 DR. ZIEMER: Yeah.

13 MR. ELLIOTT: -- I'm going to send these
14 to you and I want to make sure I get the right
15 ones to the right people.

16 DR. ZIEMER: One, two and three --

17 MR. ELLIOTT: One, two and three go to -
18 -

19 DR. ZIEMER: -- Presley and Anderson.
20 Four, five and six go to --

21 MR. GRIFFON: (Off microphone) Roy and
22 Gen.

23 MR. PRESLEY: (Off microphone) Roy and
24 Gen.

25 DR. ZIEMER: Right, Roessler and DeHart.

1 Seven, eight, nine go to Andrade and Griffon.

2 MR. GRIFFON: Then we skip one, just so
3 Larry knows. Right?

4 DR. ZIEMER: What? Then -- well, this
5 now becomes ten.

6 MR. GRIFFON: Right.

7 MR. PRESLEY: (Off microphone) Savannah
8 River --

9 DR. ZIEMER: Ten, 11 and 12 will be
10 Gibson/Ziemer; 13, 14, 15, 16 --

11 MR. ELLIOTT: (Off microphone)
12 (Inaudible) 14.

13 MR. PRESLEY: (Off microphone)
14 (Inaudible) 14.

15 DR. ZIEMER: Huh?

16 MR. PRESLEY: (Off microphone) 13 and
17 14.

18 DR. MELIUS: Richard and I.

19 DR. ZIEMER: I have four of them for
20 you.

21 DR. MELIUS: (Off microphone) Yeah, we
22 have --

23 DR. ZIEMER: I have 13, 14, 15, 16,
24 Melius and Espinosa.

25 DR. MELIUS: (Off microphone)

1 (Inaudible) 18 was up, too, you know.

2 DR. ZIEMER: And then Leon and Munn will
3 be 17, 18, 19, 20. Okay.

4 MR. ELLIOTT: Just so I make sure, can I
5 read --

6 DR. ZIEMER: Yep.

7 MR. ELLIOTT: Okay, if you number these
8 and you drop out the bottom five Bethlehem Steels
9 so they're not numbered -- right? -- we're going
10 to give number one, two and three to Bob and
11 Henry; four, five and six to Gen and Roy; seven,
12 eight and nine to Tony and Mark; ten, 11, 12 to
13 Paul and Mike; 13, 14, 15 and 16 to Jim and Rich;
14 17, 18, 19 and 20 to Leon and Wanda.

15 DR. ZIEMER: Uh-huh.

16 MR. ELLIOTT: Okay. You will see those
17 disks coming at you next week, so we need to know
18 if you're not going to be -- where you want them
19 sent. If you're not going to be at your
20 residence, I need to know an alternate location
21 to...

22 (Pause)

23 MR. GRIFFON: They won't be there before
24 Monday, will they?

25 MR. ELLIOTT: No, they won't be there

1 before Monday.

2 MR. GRIFFON: They won't be there on
3 Monday -- or no? Okay.

4 MR. ELLIOTT: They will probably be sent
5 out Tuesday, I imagine.

6 DR. ZIEMER: Okay, thank you very much.

7 MR. ELLIOTT: Tuesday or later --
8 Wednesday.

9 DR. ZIEMER: Henry?

10 DR. ANDERSON: And as soon as we can get
11 a date for when the contractor work group's going
12 to be, it'd be helpful to know. I mean we're
13 going to be tied in to a narrow window of calling
14 --

15 DR. ZIEMER: John -- John, you'll let me
16 know and I'll transmit that then.

17 DR. ANDERSON: 'Cause we could maybe
18 shift -- if it's going to be three days, we could
19 maybe shift to meet people's schedules.

20 DR. ZIEMER: Right.

21 MR. ELLIOTT: We need to send -- Bob,
22 yours doesn't need to arrive until...

23 MR. PRESLEY: (Off microphone)
24 (Inaudible) the 13th of September.

25 DR. ZIEMER: Now keep in mind, although

1 we've grouped these by four, keep in mind that
2 the contractor could conceivably have four
3 different people for your four cases. You're not
4 necessarily working with a single contact.

5 UNIDENTIFIED: (Off microphone) Really?

6 DR. ZIEMER: Sure, because they're going
7 to assign them based on expertise. We have
8 assigned them, in a sense, arbitrarily. But no
9 matter how you cut it, that's -- you're not --
10 you're not necessarily going to be with one
11 person.

12 DR. MELIUS: And I think we also have to
13 recognize that it just may not be logistically
14 possible for -- I mean (Inaudible) my schedule,
15 some other people's, just try to pick out a date
16 and times, it's going to be very, very hard.

17 DR. ZIEMER: And incidentally, the
18 participation in the conference call would not
19 necessarily be mandatory. If you're going to be
20 on travel but had comments, you'd simply transmit
21 them -- you're going to get feedback in any event
22 from the contractor. Okay?

23 We need to take a lunch break and then
24 aft-- first thing after lunch, at 1:30, is a
25 public comment period. Let me -- I think we have

1 had some sign-ups, have we not, for public
2 comment? We have at least one comment. And then
3 we will proceed -- we have some other working
4 items to take care of, including the minutes and
5 the other documents from the contractor. So
6 let's adjourn till 1:30 -- or recess till 1:30.
7 We're not adjourning. You can leave your stuff
8 here.

9 (Whereupon, a luncheon recess was
10 taken.)

11 DR. ZIEMER: Just for the record, Henry
12 Anderson, Mike Gibson and Roy DeHart have had to
13 leave, so are not here for this afternoon
14 session. We still have a quorum, however, and we
15 will proceed.

16 PUBLIC COMMENT

17 This will be our public comment period.
18 We have two individuals that have requested
19 time. We'll begin with Richard Miller. Richard,
20 the floor is yours.

21 Is there a mike -- hang on, it's coming.

22 (Pause)

23 MR. MILLER: Good afternoon. My name is
24 Richard Miller -- is that too loud?

25 DR. ZIEMER: That's good.

NANCY LEE & ASSOCIATES

1 MR. MILLER: I'm with the Government
2 Accountability Project. I apologize for not
3 being at the last meeting, but I'm glad to be
4 back.

5 I wanted to touch on several items
6 today. The first is Blockson Chemical. We
7 understand that earlier this week the Federal
8 Register notice was published which changes yet
9 again the definition of what is Blockson
10 Chemical. We've discussed previously -- the
11 policy issue here is whether you count the radon
12 dose at the Blockson Chemical facility from the
13 grinding of rock phosphate, and a year ago in
14 July the Department of Energy published a notice
15 which narrowed the Blockson Chemical facility to
16 only building 55, which was where they
17 precipitated out the uranium from the phosphoric
18 acid. But the question was whether earlier steps
19 in the chain had radiological consequences or
20 potential consequences and whether that dose
21 should be counted or not.

22 And then I, you know, just meandered
23 onto the NIOSH web site and lo and behold we see
24 that there is yet another site profile published
25 at the end of June for Blockson Chemical. And I

1 couldn't tell whether it was my computer or
2 whether it was the document, but page nine seemed
3 to be blank. And I don't know if that's true or
4 not, but if -- is -- has the question of whether
5 radon is going to be counted been resolved in
6 terms of the adjudication, particularly of the
7 lung cancer cases, or is that still an unresolved
8 issue?

9 DR. ZIEMER: Do you or Jim want to
10 answer that?

11 MR. ELLIOTT: We haven't seen -- I'll
12 look at the site profile. I'm concerned about
13 page 19 being blank, so --

14 MR. MILLER: Nine.

15 MR. ELLIOTT: -- I'll check -- I'll
16 check that out -- page nine?

17 MR. MILLER: Page nine, yeah. Which was
18 the one which referred to radon dose, so I just -
19 -

20 MR. ELLIOTT: That may be the reason why
21 it's blank then --

22 MR. MILLER: That's why --

23 MR. ELLIOTT: -- because we had reserved
24 --

25 MR. MILLER: -- I'm asking.

1 MR. ELLIOTT: We had reserved that until
2 we've fully considered the situation. I have not
3 seen the Federal Register notice, nor were we
4 notified by DOE that it was being changed. It
5 was a surprise to us as it was to you. We still
6 are considering how to go about reconstructing
7 lung cancer doses and what we will do with regard
8 to radon. We haven't arrived at a decision point
9 on that.

10 MR. MILLER: So the revised site profile
11 that's up doesn't -- doesn't close out that issue
12 is what --

13 MR. ELLIOTT: No, it does not.

14 MR. MILLER: Okay, that's -- that's what
15 I really wanted to get clarified on. Is -- is it
16 -- is it sensible -- is this a sensible question
17 for the Advisory Board to be taking up, I mean
18 what dose do you count or not count? I mean
19 doesn't that fall kind of within what this Board
20 ought to be deliberating on, or is -- it just
21 sort of strikes me -- I mean this has been
22 hanging out there since October of 2003 when the
23 first site profile was published. Now we're sort
24 of winding the clock, it's -- you know, we're --
25 you know, we're pushing to the fall of 2004. A

1 full year has passed. The issue's not resolved
2 or closed, and you all haven't really had a
3 chance to deliberate on this. And you know -- I
4 mean Larry's obviously wearing the hat of the
5 dose reconstructor. You're wearing the hat of
6 the -- you know, the site profile manager, but
7 you're also the one setting the agenda here. Is
8 there a way to get this on the agenda once and
9 for all and get it aired out and get at least
10 some recommendations, whether the government
11 accepts them or not?

12 DR. ZIEMER: I think the answer is yes,
13 there is.

14 MR. ELLIOTT: Yes, there is. But the
15 Department has not determined that it's an agenda
16 item for the Board to take up at this point in
17 time, so we'll have to come to our closure on it
18 and provide it to the Board for its deliberation
19 when the -- when it is appropriate.

20 MR. MILLER: Okay. Well, there's a
21 draft site profile out there, so I figured it was
22 appropriate once one's been published.

23 The second issue I wanted to touch on
24 was the Special Exposure Cohort. You've got, as
25 noted, several petitions filed. I wanted to

1 comment particularly on the Mallinckrodt one
2 because I understand it'll be one of the first
3 ones you all get, and I heard mention -- at least
4 yesterday and it may-- probably wasn't a complete
5 answer from -- from NIOSH staff, but they said
6 well, we're looking at that sort of '42 to '46
7 time period on -- on getting some kind of report,
8 I guess was -- was -- was -- I don't want to
9 characterize the words because they are what they
10 are. Our sense of this -- looking at the
11 Mallinckrodt site profile, at least -- is there's
12 more to the Mallinckrodt site and whether dose is
13 reconstructible than merely whether there was
14 internal or external bioassay data undertaken
15 between '42 and roughly '48. I believe they
16 started doing some external dosimetry in around
17 '46, and started doing more internals starting
18 around '48. But there are -- the whole raffinate
19 process where they took basically the -- the --
20 the -- where they made filter cake, where they
21 extracted the liquid raffinate, which was loaded
22 with all of the actinium-bearing -- particularly
23 actinium-bearing waste and other materials that
24 were ultimately shipped to Mound -- right? None
25 of that's been assessed in the site profile.

1 There's no actinium dose estimates. It's not
2 even mentioned. I did a keyword search just to
3 make sure it might have been mentioned, yet we
4 know there's a lot of it. We know it's oozing
5 out of the airport site where they dumped the
6 raffinates in St. Louis. If that dose isn't
7 estimable, why is that not also part of the
8 consideration of what dose can or can't be
9 reconstructed? I mean why is that outside the
10 scope of -- of your research -- or is it? Am --
11 am -- am -- am I prejudging and -- I -- you know,
12 where y'all are headed with this? I mean that's
13 -- I guess it's half a comment, half a question.

14 MR. ELLIOTT: Well, Richard, this is a
15 public comment period so your comments are noted
16 and I'm not going to respond to questions of this
17 -- this sort and type. It's premature. So --

18 MR. MILLER: Right.

19 MR. ELLIOTT: -- please -- please
20 constrain your comments to comments, if you
21 would.

22 MR. MILLER: Well, I may --

23 DR. ZIEMER: Well, the information is
24 noted in the --

25 MR. MILLER: I mean I think -- I think

1 this is not the first time that issue's been
2 raised, but I -- I -- I am reacting to what we
3 heard earlier in terms of the assessment of that
4 petition and --

5 DR. ZIEMER: We hear what you're saying.

6 MR. MILLER: -- and -- and I would
7 encourage that inquiry.

8 The second issue has to do with how this
9 Board assesses the Special Exposure Cohort
10 petition. And -- and although it -- it -- the --
11 what le-- was left, at least from my perception,
12 of unresolved in the SEC rulemaking and in the
13 procedures which were posted, I guess, after your
14 last Board meeting and -- and which have had a
15 chance to read -- left me with this puzzle. If
16 your SEC -- if you're going to determine that
17 it's not feasible to estimate dose because you
18 can come up with a maximum plausible worst-case
19 dose estimate, but that is not the estimate which
20 is going to be used for compensating cases where
21 P of C exceeds 50 percent -- so in a non-
22 efficiency framework -- what happens? Who falls
23 through the cracks and how do you -- what's --
24 what's -- yeah, what -- what is the logic of --
25 what is the logic of your decision point? What

1 is the logic of the decision point? And I think
2 you all need to rethink, re-examine -- as you get
3 your first petitions in and think about your
4 analysis, are we having people for whom there --
5 they're in the class, you determine that you
6 could come up with a worst-case dose estimate for
7 them, but it turns out it's over 50 percent, so
8 we're not going to apply the worst-case dose
9 estimate to those people; we're going to try to
10 come up with a better estimate. But you can't
11 come up with a better estimate, but nevertheless
12 there you are. They're not also eligible for the
13 Special Exposure Cohort petition. And I -- I --
14 I just think this is a question y'all have to --
15 to wrap your minds around again. I -- I know
16 you've heard me raise this more than once.

17 DR. NETON: (Off microphone) (Inaudible)

18 DR. ZIEMER: Response from Jim Neton.

19 DR. NETON: I know we're not supposed to
20 respond to comments, but when they're -- when
21 there's some factual issues, I think it's best to
22 correct them --

23 MR. MILLER: Go right ahead.

24 DR. NETON: -- at this point. I think
25 you're mistaken, Richard, that if -- if a -- if

1 the worst-case estimate would put somebody over
2 50 percent, we would use that as the dose
3 reconstruction if that is the only value we had
4 to reconstruct the dose. I don't know where you
5 got the idea we wouldn't.

6 MR. MILLER: 42 CFR 82.10(k) says you
7 will use a worst-case dose estimate up to the
8 point that it -- you will apply that, provided
9 that the P of C -- it's -- it's for your
10 efficiency process.

11 DR. NETON: No, the efficiency process,
12 though -- the worst-case estimate can be used if
13 that is the only estimate that you have
14 available. You cannot use a worst-case estimate
15 if there is a refinement that can be done. In
16 other words, you can't -- you can't start the
17 efficiency process and say my worst-case estimate
18 is it's -- it could come to 40 rem and that's
19 compensable. You can't stop there, because if
20 there's additional information, one could refine
21 the estimate. You can't award a compensation
22 case based on an incomplete research profile.

23 MR. MILLER: Oh, absolutely.

24 DR. NETON: So what I'm saying is, if --
25 but if you go and it's a worst-case estimate and

1 there is no refinement available, that's all you
2 know, then that's what you would use. You have
3 to. There is no other information available. So
4 I don't...

5 MR. MILLER: Well, then -- then -- then
6 the question I guess will be when you set your
7 thresholds for what constitutes capping the dose,
8 the test will then be are there cases where you
9 have capped the dose -- right? -- which you are
10 not going -- which would fall on that side of a -
11 - we can reconstruct the dose and we've capped it
12 and so therefore we know that this population,
13 this subset of the cohort, for example, has --
14 has -- has -- then going to be compensated
15 accordingly.

16 DR. NETON: It does not necessarily mean
17 be-- and we went through this at the last Board
18 meeting, and you weren't here so I guess that's
19 why there's a little bit of confusion. But it is
20 possible to say that we can cap a dose and -- and
21 determine that a cohort should not proceed
22 forward in the SEC process. That does not mean
23 that NIOSH would not do further research to
24 refine the dose as necessary in accordance with
25 the regulation.

1 MR. MILLER: Well, we'll -- we'll --
2 we'll quickly see how that plays out in practice.

3 MR. GRIFFON: (Inaudible) where we went
4 last time in Buffalo and we did have this
5 discussion, and it was probably mainly me, but
6 where we went with that was that, you know,
7 capping that dose to exclude someone from an SEC
8 -- you know, my argument was well, you could say
9 they got, you know, 4,000 -- you know, maximum
10 estimate could be 4,000 rem, but you're not
11 locked into having to use that --

12 DR. NETON: I think there's some --

13 MR. GRIFFON: -- so --

14 DR. NETON: -- some language in the
15 regulation that says there has to be some sort of
16 a reasonable upper cap. One cannot say a million
17 rem. So it's in there.

18 DR. ZIEMER: Okay. Proceed, Richard.

19 MR. MILLER: Sure.

20 DR. ZIEMER: Do you have additional
21 comments?

22 MR. MILLER: Yes. The -- the -- the --
23 the second thing I'd just like to shift gears to
24 is the -- I guess just a sort of a personal
25 response, which it was hard not to sit in the

1 audience, and I don't know what it felt like to
2 be around the table, but it was hard not to sit
3 in the audience yesterday and feel a certain
4 twinge of anxiety as the presentation by the
5 audit contractor played out before the Board.
6 And -- and I guess -- the good news was, it
7 appears as though the records access issue seems
8 to now be resolved, that -- that -- that that
9 problem is now behind us and I -- and I hope
10 that's the case.

11 The second question that didn't seem
12 quite as clearly resolved, although there were a
13 number of constructive suggestions from Tony and
14 from Bob Presley and others about the Q clearance
15 issue, is that if the Q clearance issue does turn
16 in -- become an obstacle to actually completing
17 these, what can we do? Is there somebody who
18 could become a champion to make sure that the
19 needed and necessary Q clearances are obtained?
20 I mean is -- is there -- is -- is there somebody
21 who can sort of take ownership of this, either in
22 the ag-- whatever the relevant agencies or the
23 Chairman of the Board -- I don't know who the
24 right person is to be the champion to make sure
25 it happens. Because if a year from now we come

1 back and we're still waiting with Q clearances in
2 the pipeline, I think there's going to be some
3 frustration again.

4 DR. ZIEMER: No. Your comment is noted
5 and we are asking the same question.

6 MR. MILLER: Oh, okay.

7 DR. ZIEMER: Who will our champion be to
8 get that done, but thank you for --

9 MR. MILLER: Yeah, okay.

10 DR. ZIEMER: -- underlining that.

11 MR. MILLER: Yeah. And -- and now --
12 and then -- and -- and hopefully here, again, the
13 issue about DOE access -- I was -- I was
14 comforted to hear Tom Rollow once again reassure
15 that the letter had been transmitted down through
16 the field and tha-- and tha-- and that there's
17 hope for -- for cooperation from -- from the DOE.

18 Having said all of that, I -- I hope
19 that this is now -- that this process is now
20 going to steer more smoothly and -- and that
21 there are not structural problems that are
22 underpinning the multi-faceted role that NIOSH is
23 having to play, which is -- is a tightrope, a
24 delicate rope to walk, but it is hard not to put
25 it on the record and say it's noticed and that

1 there's -- there's some difficulty there. And I
2 don't know what all the background conversations
3 are. I don't know what all the facts are. I do
4 know that when it plays out publicly here,
5 there's more to it than what meets the eye. I
6 don't know what's necessary to bring greater
7 transparency to it. Maybe there isn't any --
8 anything more to be dealt with. But I hope that
9 there's not a structural problem here in NIOSH
10 accommodating the contractor's needs, whether it
11 be in contract management, records access or
12 whatever new is going to come up on the horizon.

13 And if there is a structural problem, if there's
14 a governance issue here, then I -- I just think
15 the Board should, as I'm sure it will, keep its
16 ears closely attuned to this question.

17 Finally, I wanted to talk a little bit
18 about what I think are the -- the -- probably the
19 most interesting aspect of the audit process
20 that's moved forward so far, and I've gotten
21 phone calls and communications from people who
22 have met with the audit contract team at -- at
23 the two locations that -- I think -- I don't know
24 how many they've been to, but at least the two
25 I've heard from -- which is that people felt

1 really good about being able to communicate.
2 There was a high sense of comfort level that they
3 were being listened to, whether -- how -- how
4 it's going to be accounted for remains to be seen
5 in whatever reports you get, but that these site
6 interviews give people a chance, collectively, to
7 -- and particularly for those with expertise --
8 to provide additional information and data that
9 may not be fitting into the process as it is.

10 And secondly, I think it'll be a useful
11 reality check against what NIOSH has encountered
12 in the paper records and their own interviews, in
13 their claimant interviews. And I would certainly
14 hope that -- that the site interview process
15 continue forward because I -- it looks to me like
16 this is going to be a value-added component as
17 you went forward.

18 And then lastly we heard from a
19 gentleman last night who worked at the special
20 manufacturing facility, the SMC, the depleted
21 uranium tank armor facility out here at INEEL.
22 Does anybody know, was the SMC facility included
23 in the site profile? Anybody know? Yes? No?

24 DR. ZIEMER: A couple of people here
25 might -- yes is the answer.

1 UNIDENTIFIED: (Off microphone) It is
2 included.

3 MR. MILLER: It is -- SMC is going to be
4 included in the -- in the site profile? Okay.

5 UNIDENTIFIED: (Off microphone) It's
6 there now.

7 DR. NETON: (Off microphone) It's there
8 now.

9 MR. MILLER: It's there now. Okay. We
10 looked on the web site last night for the
11 internal dose section and that -- that, I guess,
12 hasn't quite made it up on the web.

13 DR. NETON: (Off microphone) It lags
14 behind a day or so.

15 MR. MILLER: Yeah, okay. Thank you.

16 DR. ZIEMER: Thank you, Richard. Now
17 we'll hear from David Fry with PACE. David did
18 address us last night and he has some additional
19 remarks today.

20 (Pause)

21 MR. FRY: Okay, I just wanted to make a
22 couple of comments. Last night I asked about if
23 they would redo the site profile meeting here
24 because, you know, we were -- we didn't have all
25 the information before, like we didn't have the

1 internal dose document. And last night we heard
2 that it was on the web. I'm not picking on
3 anybody, but as soon as we left I went and looked
4 on the internet and it's not on the web yet. It
5 says still under development, so I think we kind
6 of need that document, you know, before we can do
7 another site profile.

8 And also on the occupational
9 environmental dose and the external dosimetry, we
10 noticed they hadn't been updated since the April
11 28th meeting, so a couple of concerns we had.

12 And then on the minutes that we got back
13 from ORAU on the first meeting that we had, and I
14 think Richard Miller just addressed one of them
15 on the SMC project, if it was covered or not.
16 There was one comment that there's a good
17 description of the procedures but little about
18 actual exposure, and we didn't really get a clear
19 answer on that. Another comment was -- it says
20 only ten percent of doses are reported. How can
21 NIOSH or ORAU make conclusions when the amounts
22 reported are inaccurate. That was the concern
23 that was brought up, and Bill Murray's written
24 response was the calculations are best -- based
25 on DOE records. It's the only way we can do it.

1 There's no way to verify if the data are good or
2 bad, so it's kind of a concern there if we can't
3 -- can't verify the data, you know, how do we
4 know what we have, really. So just -- just a
5 couple of things I wanted to bring up.

6 DR. ZIEMER: Thank you very much. As
7 far as I know, that's all of the individual
8 comments that have been requested.

9 UNIDENTIFIED: (Off microphone)
10 (Inaudible)

11 DR. ZIEMER: Yes, please approach the
12 mike.

13 (Pause)

14 UNIDENTIFIED: (Off microphone) Is this
15 okay? Okay, one thing I understand --

16 DR. ZIEMER: You'll need to identify
17 yourself for the record.

18 MS. CODDING: Oh, okay, my name is
19 Shirley Coddling. I made a comment last night,
20 and then this morning I heard that you guys are
21 going to be touring the site tomorrow. And my
22 one big concern is you're going to go out to the
23 site and you're going to see a site that is not
24 what we knew in the six-- well, even fifties,
25 sixties, seventies and eighties. You're going to

1 see a much cleaner place.

2 They're not going to take you in the
3 areas that we are all concerned about where we
4 have picked up all the problems. You're going to
5 go out and see a site and walk away from there
6 saying what in the world are they complaining
7 about, because I guarantee you, if you looked --
8 before -- in the PODs, the orders -- the daily
9 orders, before every tour is a massive -- for
10 days before that -- clean up, clean up, clean up,
11 make it look good. And personally, I think
12 that's how we got our star status. Before those
13 tours, we're out there -- that's our primary job,
14 clean-up.

15 And so you're not going to -- you're not
16 going to go in the areas -- number one, like the
17 old calciner. When we worked an overtime, if you
18 were held from a graveyard to a day shift, you
19 prayed you got that as a job because you could go
20 down there, put your feet up and relax 'cause no
21 manager in his right mind was going to come in
22 there. I don't think a manager had been in the
23 old calciner since the seventies. You're not
24 going to see it because we deconned the best we
25 could, tore the building down on itself and

1 capped it with concrete that's five feet tall off
2 of the ground. You're not going to see that.

3 You're not going to see the deep tanks
4 at all where some of the fuel processing
5 operators went down and were horrendously
6 exposed. You're never going to see it because
7 nobody goes even near there now.

8 The solvent tank is long gone. You're
9 not going to see that, not only the radiation,
10 but the chemicals that we were exposed to back
11 then that they don't allow on the site anymore.
12 There's a -- half of the chemicals I worked with
13 in the eighties I'm not allowed to even touch
14 now.

15 You're going to see a much safer site.
16 We don't even go above six foot on a ladder
17 without a safe work permit, but in the old
18 calciner, I was crawling up pipes to get in the
19 overhead pipes to manipulate a valve because we
20 had a leak, and I went up there with nothing but
21 a pair of NICs* on, gloves and shoe covers.
22 You're not going to see any of that.

23 You are not seeing the real site
24 tomorrow. And I really want you to be aware of
25 that when you go out there, that what you're

1 seeing is what they want the public to know
2 about. It's not what was going on, and
3 particularly in the sixties and seventies and the
4 eighties.

5 We stopped using the injection well I
6 believe in 1986. As an operator, when we'd be
7 ready to send out our evaporator, overhead
8 condensates, we'd go over and turn up the
9 detectors one because we knew it was going to set
10 off an alarm. Well, you want to get rid of the
11 stuff. The company told us to go ahead and do
12 that. We turned up the detectors. We weren't
13 supposed to turn it up to ten to the fourth, but
14 I know of two times for sure that it was done
15 just because we had to get rid of the stuff. It
16 went into the injection well. That went down to
17 the aquifer. You've got your Snake River
18 alliance*, your Jackson Hole people that finally
19 put a stop to that 'cause they were screaming
20 we're -- we're not doing things right at the
21 site. That is what you're going to see now is
22 the changed, not what was, not the way we worked.

23 Also, I'm sure you've gone around town
24 and you've noticed we have no industry in this
25 town. This town has put all of its eggs in one

1 basket and that's the site. So if you wanted a
2 good paying job and you did not have a degree,
3 you weren't a doctor, you weren't an attorney,
4 you weren't a big farmer, you went out to the
5 site. And because everybody wanted to go out to
6 the site for the good-paying job, there were 50
7 to 100 people waiting for your job if you didn't
8 do your job. The company told you to jump, you
9 asked how high, because if you didn't, there was
10 -- there was 50 operator -- 50 people lined up
11 for my one operator job. I did what they told
12 me. They wanted me to go in in my birthday suit
13 in the cell, I would have -- and thank God that
14 didn't happen 'cause it made everybody happy.

15 Seriously, that's how it was. We would
16 have done anything that they asked. HPs, VoTech
17 gave a class at -- for -- to certify us in HP.
18 They were pumping out HPs like you can't believe.

19 Yeah, you better believe the HPs did what they
20 were told, because there were 200 waiting to take
21 their job. We didn't ask questions; we did. And
22 we did it to the best we could, and plus -

23 You know, when you're young, you're
24 invincible. I can do anything. I'll survive it.

25 And now a lot of people I worked with are dead.

1 They really are. They're gone. Or they're in
2 such horrendously bad condition -- I'm one of the
3 lucky ones. I've survived eight surgeries on my
4 head. I am a lucky person. Do you know, I've
5 lost two sup-- no, three supervisors now. HPs
6 that I've worked with hand-in-hand have died of
7 cancer. We sent things into the stack that now
8 we -- we monitor so close you can't believe. We
9 sent things in the injection well that went to
10 the aquifer. We -- we prayed for a job in the
11 old calciner 'cause the manager wouldn't come in
12 and catch you resting 'cause, you know, from --
13 overtime from the graveyard shift to day shift
14 was really hard. You wanted that. But nobody --
15 we had a coffeepot down there, for crying out
16 loud, to help keep you awake. But a manager
17 wouldn't go downstairs. If he needed to talk to
18 you, you went up and talked to him. Nobody went
19 down there.

20 You guys aren't going to see anything
21 like that. You're going to see a nice clean,
22 wonderful place to work. That's not what we
23 worked in. That is the new and improved site,
24 and it is done only because of public outcry on
25 it. It is done because we were dumping stuff

1 into the ground. We were --

2 Do you know -- just a few months ago we
3 even put a sealant on the tank farm. Now you're
4 going to look at it and say, you know, nothing's
5 going down into the ground there. Twenty-three
6 years I worked, there were valves that leaked
7 among* the tank farm. They dug up some dirt in
8 the tank farm that were hotter than heck.

9 Three to four years ago I went to Petco
10 and bought rabbit food because us gals in the
11 operation befriended some rabbits, and so in the
12 wintertime we -- I bought rabbit food. I took it
13 out there. We had two rabbits that let us girls
14 get pretty close to them, and -- but the guys,
15 when they'd walk by and say something, the
16 rabbits took off 'cause the guys kept saying
17 fatten them up so we could eat dinner. And --
18 but we finally last summer got an e-mail that
19 said no more feeding the rabbits; we're finding
20 hot rabbit turds.

21 And I was out once and Craig Bishop, an
22 HP, was picking up goofy things off of the tank
23 farm and out in front of 604 where I worked,
24 picking -- and I was what are you doing? He said
25 collecting rabbit turds, survey. And he said

1 some of these are screaming hot, and he put the
2 monitor there and it pegged out* like you
3 wouldn't believe. We've got rabbits walking
4 around all over there that are hotter than a son-
5 of-a-gun, and yet we walk all over there.

6 The dirt on the tank farm -- they did
7 take a couple shovelfuls that were so screaming
8 hot -- so now we got a nice asphalt cover over
9 it. You guys'll never see that. You're not
10 seeing the real thing. You have no idea what
11 we've been through, and it's not the same area.
12 We don't even work like we used to.

13 And that's all I was just going to say.

14 I just want you to be aware of what you're
15 seeing tomorrow is not what is.

16 DR. ZIEMER: Thank you for those
17 comments, and I think the Board is certainly
18 aware of that. Thank God that it isn't the way
19 it was -- and this is true at all the sites we
20 visit. They're very different than they were.
21 And of course, you know, when I -- when I have
22 company at my house, my wife doesn't let them
23 look in my closet, either, and it -- obviously
24 we're not going to see everything. We do want
25 the Board to have a feel for what the site --

1 what is the site, where did all this occur. So
2 we -- but we understand what you're saying and we
3 appreciate those comments.

4 Is there anyone else that wishes to make
5 a comment? If not, we're going to proceed on the
6 agenda.

7 REVIEW AND APPROVAL OF DRAFT MINUTES, MEETING 25

8 We have a number of additional items to
9 take care of in our working session, beginning
10 with the minutes of our last meeting. I'd like
11 to call for any changes or additions to the
12 minutes. Wanda?

13 MS. MUNN: I'd like a couple of
14 clarifications, I think, on one or two sentences
15 that must have -- it must have made sense to me
16 at the time, I was there, but when -- reading
17 them later, I wasn't sure. The very last
18 sentence on page seven says the site profiles are
19 not applicable to workers with no monitoring
20 information at all. I'm not sure exactly what
21 that means.

22 DR. ZIEMER: That's quoting Dr. Neton or
23 summarizing Dr. Neton's comments. Jim, it -- the
24 last sentence on page seven says the site
25 profiles are not applicable to workers with no

1 monitoring information at all, and she's asking
2 for a clarification I think on that sentence.

3 MS. MUNN: Yes.

4 DR. NETON: Yes, that -- that's what I
5 said or a good summary of what I said. What I
6 meant by that is that the site profiles were
7 really -- the first pass at the site profiles
8 were constructed to evaluate people with
9 monitoring information -- TLDs, urine samples,
10 that sort of thing. People that had no
11 monitoring information at all, it would be very
12 difficult to use the site profile to do a dose
13 reconstruction because we wouldn't have incident
14 reports or coworker data to evaluate that. So I
15 think it might be a little strong. I might -- I
16 might rephrase that to say are not necessarily
17 applicable, because there may be some situations
18 where we could do it. I can't think of any off
19 the top of my head.

20 DR. ZIEMER: Well -- but the point is,
21 this does fairly reflect what you said.

22 DR. NETON: Yes.

23 DR. ZIEMER: Okay?

24 DR. MELIUS: If you go to page 50, the
25 bottom of the page is -- there's two sentences

1 from which that sentence is abstracted from,
2 which I think capture Jim's --

3 DR. ZIEMER: This is in the executive
4 summary versus the detailed -- yeah.

5 DR. MELIUS: Yeah, and --

6 DR. ZIEMER: So unless you object, can
7 we leave the first one since he's indicated it is
8 correct?

9 MS. MUNN: Yes. Yes, that's fine.
10 That's fine.

11 DR. ZIEMER: Okay. Another one, Wanda?

12 MS. MUNN: I didn't have any problem
13 with the one on 55. On page 16 --

14 DR. ZIEMER: Sixteen?

15 MS. MUNN: Uh-huh, the first paragraph
16 of Ms. Mosier's Labor status report. I -- I made
17 some reference to that earlier. I believe I
18 understand exactly what that means, but I wonder
19 whether everyone who reads this understands that.

20 DR. ZIEMER: This is the first sentence,
21 starting with "Ms. Mosier"?

22 MS. MUNN: The first paragraph,
23 presented statistics -- a breakdown of categories
24 -- cancer remaining the major category at 70
25 percent. Then the next sentence says the next

1 largest is non-covered conditions, which is 49
2 percent. And I understand that there's an
3 overlap there, but I wonder whether the ordinary
4 reader would in fact wonder how you can have 70
5 percent and then have 49 percent not covered.
6 Now I -- you know, I get it, but I'm not at all
7 sure that it's clear.

8 DR. ZIEMER: Because you can have some
9 with both.

10 MS. MUNN: Yes.

11 DR. ZIEMER: I guess the issue would be
12 70 percent of what.

13 MS. MUNN: Yeah, uh-huh.

14 DR. ZIEMER: And Ms. Mosier isn't here,
15 but I think it was 70 percent of all -- I'm not
16 sure.

17 MS. MUNN: No.

18 DR. ZIEMER: Seventy percent of all
19 claims?

20 DR. MELIUS: Couldn't -- couldn't
21 someone refer back to the presentation that they
22 made at the last meeting. You still have the
23 slides. Someone may have kept them. And just
24 sort of treat it as a grammatical error and it
25 can be clarified --

1 DR. ZIEMER: I don't -- I think the
2 numbers are probably right.

3 MS. MUNN: I think they are, too.

4 DR. ZIEMER: You could have 49 percent
5 other conditions, and some of those are overlaps
6 where they have cancer and some -- I think is
7 what the situation --

8 MS. MUNN: I think that's what it is,
9 too, but it's not clear just reading it, prima
10 facie.

11 DR. ZIEMER: I'm not sure what we'd do
12 with it at this moment.

13 MS. MUNN: I'm not sure, either, but I
14 felt it was confusing. The next --

15 DR. ZIEMER: Maybe -- maybe the way to
16 treat it is to say which is 49 percent and which
17 may include some of the -- and which could also
18 include the can-- some of the cancer cases, or
19 something to that effect.

20 DR. MELIUS: Or if we want to fix it
21 here, we can just take out the numbers, just --

22 DR. ZIEMER: Cancer the major category
23 and the next largest is non-covered conditions.

24 DR. MELIUS: That way we don't...

25 DR. ZIEMER: That certainly removes the

1 ambiguity. Anyone object? And the transcript
2 will have the exact -- without objection, we'll
3 just remove the percentages there so that it --
4 so we would remove the words "at 70 percent" and
5 remove the words "which is 49 percent". Thank
6 you.

7 MS. MUNN: In the paragraph above that I
8 think we need to add one word to the second
9 sentence of the last paragraph in that section.
10 It starts "So long as the Board decided
11 correspondence should be generated", I think the
12 word "and" needs to go in there, doesn't it?

13 DR. ZIEMER: Yes, "and determines the
14 purpose and focus".

15 MS. MUNN: Yes.

16 DR. ZIEMER: The word "and" will be
17 inserted there, take it by consent that's a
18 grammatical.

19 MS. MUNN: Then my only other comment is
20 the bottom of page 39 where, without any prelude,
21 we sort of -- it looks as though Ms. Munn
22 promptly -- suddenly decided she wanted to
23 announce that she'd never heard anyone making
24 jokes, and I guess I would like to suggest a
25 change to that --

1 DR. ZIEMER: Yes.

2 MS. MUNN: -- without changing the
3 meaning. I would suggest "Ms. Munn commented she
4 felt it was necessary to dispute an earlier
5 inference that some individuals might not
6 approach these claimant issues seriously. She
7 stated that no person had ever made jokes about
8 these matters within her hearing." I would ask
9 that that be substituted for the first sentence.

10 DR. ZIEMER: Is there any objection, and
11 you can provide that wording to the --

12 MS. MUNN: I will.

13 DR. ZIEMER: -- to the staff and to the
14 editor.

15 MS. MUNN: Thank you.

16 DR. ZIEMER: Without objection, we'll
17 clarify that. Thank you.

18 Larry, you had one?

19 MR. ELLIOTT: Yes, on page five, under
20 Oak Ridge Associated Universities Team Dose
21 Reconstruction Project for NIOSH Claimant
22 Contact. The last sentence in the first
23 paragraph that reads "They now handle almost all
24 mailings to claimants" should correctly read
25 "They now handle almost all CATI mailings to

1 claimants."

2 DR. ZIEMER: That's a acronym, C-A--

3 MS. MUNN: T.

4 DR. ZIEMER: -- D-E?

5 MR. ELLIOTT: C-A-T-I.

6 DR. ZIEMER: C-A-T-I.

7 MR. ELLIOTT: Computer -- that's an
8 acronym for computer-assisted telephone
9 interviews.

10 DR. ZIEMER: They now handle all --
11 almost all CATI mailings to the claimants.
12 Without objection --

13 MR. ELLIOTT: The reason -- the reason
14 why it makes it correct is that ORAU does not
15 handle all mailings to the claimants, but they --
16 I guess they handle almost all, if not all,
17 mailings on the CATI.

18 DR. ZIEMER: Without objection, we'll
19 make that change.

20 Any others?

21 (No responses)

22 DR. ZIEMER: Motion to approve the
23 minutes with these changes?

24 MR. PRESLEY: (Off microphone) So moved.

25 DR. ZIEMER: Second?

1 UNIDENTIFIED: (Off microphone) Second.

2 DR. ZIEMER: All in favor, aye?

3 (Affirmative responses)

4 DR. ZIEMER: Any opposed?

5 (No responses)

6 DR. ZIEMER: Motion carries.

7 BOARD DISCUSSION AND WORKING SESSION

8 We had two documents from the
9 contractor. One was the organizational conflict
10 of interest plan, the other was the quality
11 assurance project plan. The contractor
12 representative indicated yesterday that they
13 themselves had some editorial changes. He has
14 given me the mark-up, and although the changes on
15 the surface appear to be minor, there are so many
16 of them and they are throughout the document, I'm
17 suggesting that we defer approval of the
18 documents, with the understanding that they are
19 operating under these general principles. And
20 most of the changes are indeed editorial. They
21 have some -- just some wording issues. And ask -
22 - I'd like to see if there's any changes the
23 Board wishes to suggest on these documents. We
24 would refer them back to the contractor to add
25 our changes to theirs and come back with a clean

1 copy next time. Is there any objection to doing
2 that?

3 (No responses)

4 DR. ZIEMER: There appears to be none.
5 Let me ask for changes -- let's start with the
6 organizational conflict of interest plan, which -
7 - the first change is going to be they're
8 changing the title of it to just conflict of
9 interest plan, but do you have any changes to
10 recommend on this? Larry.

11 MR. ELLIOTT: They have titled both of
12 these documents the National Institute of et
13 cetera, et cetera. We would ask that they strike
14 the National Institute of -- it is actually
15 National Institute for, but I don't think it
16 appropriate that NIOSH name appear on this
17 document. You are the Advisory Board. It is
18 your -- it is your contractor, it's your
19 document.

20 DR. ZIEMER: Without objection, we'll
21 ask them to strike that. Thank you. Any others,
22 Larry, that you --

23 MR. ELLIOTT: None that I have to offer.

24 DR. ZIEMER: Okay. Other -- any other
25 changes, questions Board members have? Wanda?

1 MS. MUNN: On CIO?

2 DR. ZIEMER: Well, let's see, let's
3 start -- we're still on conflict of interest. If
4 not, I will ask them to come back with a clean
5 copy -- and again, most of the changes that they
6 are recommending have to do with the use of the
7 title "Organizational Conflict of Interest" but
8 then they have some other rewording changes that
9 do not change substantively what they are doing,
10 but nonetheless, they are wording changes and I
11 think we would be more comfortable having clean
12 copy to work with.

13 So without objection, we'll defer action
14 until the next meeting.

15 Now, let's go on to the quality
16 assurance project plan. Again, we'll strike
17 National Institute of Occupational Safety and
18 Health from the title. Wanda, I think you had an
19 item on this one.

20 MS. MUNN: Yeah, I have one or two, and
21 I don't mean them as a criticism. I guess I'm
22 trying to look at them as documents covering
23 procedures and activities that someone else may
24 have to audit at some time. And I -- when
25 reading the duties of the quality assurance

1 manager, I'm assuming that there will be
2 procedures established which this individual will
3 approve and which will be the implementation of
4 the policy which this document purports to be.

5 I'm a little concerned about the
6 statement of regularly assessing documents and
7 the adequacy without any information about --

8 DR. ZIEMER: What page are you on?

9 MS. MUNN: I'm on page six of 15.

10 DR. ZIEMER: Under quality assurance --

11 MS. MUNN: Quality assurance manager --

12 DR. ZIEMER: -- manager?

13 MS. MUNN: -- yes. (Reading) regularly
14 assesses and documents the adequacy of quality
15 systems by reviewing procedures and auditing work
16 products.

17 I am assuming there will -- I would like
18 to assume that there will be a procedure which
19 will establish the frequency and the type of
20 documentation that would occur there. But of
21 course in an overall policy document like this,
22 it's impossible to spell that out.

23 DR. ZIEMER: So are you suggesting --

24 MS. MUNN: I guess --

25 DR. ZIEMER: -- a change in the wording?

1 MS. MUNN: I'm requesting just a little
2 more specificity in that wording, and I think it
3 would be better for the contractor themselves to
4 identify what that specificity should be. But
5 bearing in mind the audit function that will
6 follow -- may follow on their activities, I'd
7 like for an auditor to be able to see what the
8 quality assurance manager had done with regard to
9 that item.

10 DR. ZIEMER: Are you suggesting that we
11 specify or ask them to specify the frequency,
12 where it says "regularly"?

13 MS. MUNN: Yes.

14 DR. ZIEMER: Does "regularly" mean once
15 a year or --

16 MS. MUNN: At least --

17 DR. ZIEMER: -- once a week or --

18 MS. MUNN: At least, you know, and --

19 DR. ZIEMER: And to specify how they are
20 --

21 MS. MUNN: What reporting system would
22 be used, yeah.

23 DR. ZIEMER: Is there any objection to
24 asking for this change, or --

25 DR. MELIUS: Yeah, I -- I mean I would

1 read this as sort of a job description, what that
2 person -- you know, what they would do. And
3 there really should be some reference to those
4 specifics in -- under plans and procedures,
5 section six. And I agree they don't cover -- at
6 least I don't see it covered -- covered there, I
7 just -- and I think that would be the place to --
8 at least they -- you know, the quality assurance
9 plan should include, you know, whatever schedules
10 or whatever -- or it could -- it may well -- as
11 well go up above, but -- one place -- it could go
12 in either place, and that's what they -- so they
13 should be able to modify it in either.

14 MS. MUNN: Under plans and procedures
15 there is, again, the specific procedure of having
16 each individual read the quality plan and the
17 documentation then is a sign-off by the
18 individual that they have read that procedure.
19 It seems to me, when I was asking for something
20 in addition on the preceding page, I was asking
21 for a little more specificity as to what the
22 manager's responsibility was --

23 DR. ZIEMER: Let me --

24 MS. MUNN: -- (Inaudible).

25 DR. ZIEMER: -- suggest this. I'm just

1 marking this up 'cause this copy's going to go
2 back to them. Suppose we suggest that on item
3 three under quality assurance manager that they
4 specify frequency and documentation, either here
5 or in section six.

6 MS. MUNN: Uh-huh.

7 DR. ZIEMER: Would that be suitable?

8 DR. MELIUS: Yeah.

9 MS. MUNN: Yes, it would.

10 DR. ZIEMER: Any objection to doing
11 that?

12 MS. MUNN: No.

13 DR. ZIEMER: Okay, I take it by consent
14 that we'll ask for that change. Okay.

15 Wanda, do you have any others?

16 MS. MUNN: No, the other was something
17 I'm sure will happen in -- in procedures under
18 item nine, QAPP training, page 12 of 15. It says
19 the QA manager supervises training of each
20 individual working on the contract. I assume
21 that documentation will fall as a part of that
22 supervision and documentation.

23 DR. ZIEMER: Well, documentation as
24 referred to in the previous section.

25 MS. MUNN: The previous section, yes.

1 Uh-huh.

2 DR. ZIEMER: Do you think something
3 additional needs to be added?

4 MS. MUNN: No, other than the fact that
5 document control does not mention training
6 documents specifically, one place or the other.

7 DR. ZIEMER: So you're suggesting that
8 perhaps they add something that -- documentation
9 of training?

10 MS. MUNN: Just a tracker, yeah.

11 DR. ZIEMER: Any objection to asking for
12 that clarification?

13 Okay, Tony?

14 DR. ANDRADE: I wanted to actually get
15 even -- even a clearer definition of the quality
16 assurance manager's role and responsibilities, so
17 back to page --

18 DR. ZIEMER: Sure.

19 DR. ANDRADE: -- of 15. It's a little
20 murky on item one. It says that the quality
21 assurance manager establishes and implements
22 quality policy. Okay? Clearly anybody who's
23 done quality assurance before knows that the QAPP
24 is only the umbrella document to implementing
25 procedures. So is this person going to be

1 responsible for writing or to have written
2 implementing procedures for the QAPP? I think
3 that should be absolutely crystal clear at this
4 point, because then on the next page these
5 procedures are referred to, but nobody knows
6 who's got responsibility for writing them or
7 being responsible for having them written.

8 DR. ZIEMER: So you want clarification
9 of who...

10 DR. ANDRADE: Right, clarification of
11 whether it is the quality assurance manager that
12 is responsible -- has overall responsibility for
13 the development of quality implementing
14 procedures.

15 DR. ZIEMER: Okay. Any objection to
16 asking for clarification on that?

17 DR. MELIUS: They would just expand duty
18 number one with more specificity?

19 DR. ANDRADE: Yes.

20 DR. MELIUS: Okay.

21 DR. ZIEMER: So clarification of whether
22 the QA manager is responsible for -- what was the
23 word you used then -- for developing?

24 DR. ANDRADE: The development of quality
25 implementing procedures.

1 DR. ZIEMER: Development of quality --

2 DR. ANDRADE: Implementing --

3 DR. ZIEMER: -- implementing procedures.

4 Thank you.

5 Okay, any others? Yes.

6 MR. ELLIOTT: In both documents -- let's
7 take the QAPP first. On page four of 15 under
8 scope, also in the conflict of interest plan on
9 page six under 5.3, second paragraph, there is
10 mention here of SEC reviews. Your contractor --
11 it's not in the scope. And in the procedures and
12 the rule that we have, the research evaluation
13 reports come to the Board. The Board is charged
14 with evaluating the content of that and sending
15 us back to do more work and more development. So
16 there's no role for your contractor with regard
17 to SEC. I thought we had -- we tried to address
18 this when we developed the tasks, and it was
19 struck out of the tasks, but I see it's coming
20 back, so...

21 DR. ZIEMER: Yeah, and I think -- we may
22 have had this discussion before, but I think
23 early in the process when we were going out to
24 find a contractor, there had been mention of a
25 possible role in SEC evaluations, but that

1 certainly is not currently a task, so --

2 MR. GRIFFON: But it is -- just for
3 clarification for me, it still is part of the
4 overall original contract that -- that was bid
5 on. It just hasn't been issued as a task.

6 MR. ELLIOTT: You want to speak to this,
7 Jim?

8 MR. GRIFFON: It's in the contract -- I
9 mean it's in the -- you know.

10 DR. NETON: I don't think so.

11 MR. GRIFFON: Yeah, it's on -- I'll give
12 you the page.

13 MR. ELLIOTT: I don't think it's in the
14 contract. It was in the -- the --

15 DR. NETON: I think their bid --

16 MR. ELLIOTT: -- RFP, request for
17 proposals. At that time, when the Board put out
18 its RFP, we didn't have any -- no one had a clear
19 insight as to whether or not there would be a
20 role. But as the proc-- as the rule was
21 developed, the rulemaking ensued and the
22 procedures were developed, the Department does
23 not view that there's any role for the Board
24 contractor on SEC. The time line of processing
25 petitions and evaluation reports calls for the

1 Board to take action on those by either saying
2 yes, we agree with the eva-- the conclusions of
3 the evaluation report to add a class, or no, we
4 don't agree with the evaluation report and send
5 NIOSH back to work on it.

6 MR. GRIFFON: Okay, but I -- I thought
7 we still left -- I thought we -- if someone could
8 double-check that for me, I thought we still left
9 a placeholder and we took out specific reference
10 to a regulation because none existed, but we left
11 a placeholder that the contractor may provide
12 technical assistance in the SEC review process --
13 may provide technical assistance to the Board,
14 and it was kind of a -- a section (c) if I
15 remember in the task order contract.

16 Now I -- I don't think --

17 DR. ZIEMER: Or did it precede the task
18 orders? I think it was removed from any of the
19 task orders.

20 MR. GRIFFON: It wasn't in any of the
21 tasks. I guess it's -- it's a langua--

22 DR. ZIEMER: Oh, you mean -- but prior
23 to the individual tasks.

24 MR. GRIFFON: Right, prior to the
25 individual tasks, I thought it still remained in

1 the final...

2 MR. ELLIOTT: What does the Board
3 envision for --

4 MR. GRIFFON: Well, I don't know, I'm
5 just saying --

6 MR. ELLIOTT: -- technical support? I
7 mean --

8 DR. ZIEMER: Well, maybe we should have
9 this discussion for a moment. Let's set this
10 aside, because that's the only other thing I have
11 before me. I wanted to raise this question and
12 let me ask it.

13 We have nine petitions in some stage of
14 process, and I think an indication that some of
15 those petitions may be sort of fully ready for
16 something by our next meeting -- for what? For
17 review or just -- they'll be in the Federal
18 Register?

19 MR. ELLIOTT: Well, I made a statement
20 yesterday that we fully expect that the public
21 will be noticed in the Federal Register that X
22 number of petitions have been qualified. That
23 will -- that notice will include a brief
24 description of the petition by what site it
25 represents. I'm hopeful also that we may have --

1 I can't promise this, but that we may have a
2 class or two defined with a research evaluation
3 report for the Board's review.

4 The process that is envisioned by the
5 rule and the procedures speaks to the Board's
6 role in reviewing and evaluating, from its
7 statutory mandate, the evaluation that we do on
8 petitions and advising whether to move them
9 forward or to send us back. There's not an audit
10 or a quality aspect of that. It's just what it
11 is on its face value. You either accept it or
12 you don't accept it. And it has to be a function
13 of this Board.

14 DR. ZIEMER: Let me ask this question.
15 What -- what -- the document that comes to the
16 Board, which will be presumably the official
17 petition and an evaluation done by staff, what is
18 that going to look like in terms of content and -
19 - I think one of the questions that arises is how
20 much of it is technical information where some
21 Board members may feel uncomfortable in
22 evaluating it without the assistance of say a
23 contractor -- not for quality purposes, but
24 simply for other purposes. Or in this case, are
25 we -- we are in a different capacity 'cause we're

1 part of the decision at this point.

2 MR. ELLIOTT: That's right.

3 DR. ZIEMER: So --

4 MR. ELLIOTT: And you don't have a lot
5 of time. The time toll's on you.

6 DR. ZIEMER: We're not overseeing the
7 quality of -- like we would on a dose
8 reconstruction. We are actually part of the
9 decision itself. But my question is, what is the
10 level of technical information that this Board
11 will have to evaluate, both in terms of technical
12 depth and maybe in content -- I think -- we need
13 to be able to feel some comfort level in our
14 ability to evaluate the document.

15 MR. ELLIOTT: We -- yes, we recognize
16 that as an issue, a concern that you have. We
17 share it. We not only see the Board as an
18 audience, we see the petitioners as an audience.
19 We see the public as an audience. So these
20 things will have to be couched in terms that the
21 public can understand. We envision these will be
22 a nominal report, ten to 15 pages; a summary page
23 that includes the original petition, class
24 definition, outlines the qualification process,
25 presents a new class definition if necessary or a

1 revised class definition or a class definition
2 that melds multiple petitions together in a case
3 where we have multiple petitions for a given
4 site. That will all be encompassed in that
5 summary section. A discussion section that
6 presents the case argument or the rationale for
7 either adding a class or not adding a class, and
8 a recommendation conclusion section.

9 DR. ZIEMER: And there will --

10 MR. ELLIOTT: Yes, a similar --

11 DR. ZIEMER: -- also be an opportunity
12 for members of the public to have input on --

13 MR. ELLIOTT: Yes, that's in the
14 procedures.

15 DR. ZIEMER: -- pro or con on --

16 MR. ELLIOTT: That's right, and you hear
17 that out. It's similar to a -- the rulemaking
18 process that you went through where it's a --
19 rather than a public-noticed rulemaking, it is
20 public comment in your forum as an advisory body.

21 DR. ZIEMER: Okay. Comments on --
22 reactions -- Jim?

23 DR. MELIUS: Well, just to further
24 complicate this issue, as -- as I mentioned
25 yesterday, we will have site profile reviews and

1 individual dose reconstruction reviews underway
2 and parallel to this process that will, you know,
3 cover -- could cover some of the same sites for
4 which there are SEC petitions. And the one site
5 you mentioned yesterday as being -- Larry
6 mentioned yesterday as being likely to come --
7 come up or some possibility it'll come up at our
8 next meeting is the Mallinckrodt site, for which
9 we have a site profile review that's also going
10 on almost -- roughly the same time and could very
11 well be ready for presentation at -- at our next
12 meeting for the Board's decision on approving and
13 so forth and so on. And to me it's going to be
14 very hard to -- to separate the two. And as a
15 Board member, I may feel -- I would be reluctant
16 -- I may be reluctant, depending on what's in the
17 -- NIOSH's Mallinckrodt recommendation, to review
18 and approve or not approve that while we -- you
19 know, depending on where our -- how our site
20 profile review came down. And I can, you know,
21 envision, you know, theoretically, lots of
22 different possibilities that, you know -- again,
23 the -- our contractor finds some source of
24 information about dose that -- that NIOSH was not
25 aware of or NIOSH's contractor was not aware --

1 and vice versa. I mean there's lots of different
2 'narios (sic), and you know, whether or not --
3 even at this point I find it hard to figure out
4 whether -- what kind of technical help we might
5 need or whether we will need any assistance in
6 doing this. But we are going to have to figure
7 out how these two processes come together.

8 DR. ZIEMER: And -- and we may have to
9 actually go through the SEC process to see how
10 that plays out. At the moment, there's no clear
11 role for the contractor in the SEC process. I'm
12 going to suggest that we simply remove it from
13 these documents. We can always amend this and
14 add it if at some point we say that there is a,
15 for some reason, a role. We would basically say
16 these two documents also apply to that activity.

17 There's no reason we couldn't add it later if
18 needed. But certainly they don't have a clear
19 role now. It's not in any of the tasks. So my
20 suggestion would be -- so that we can at least
21 move ahead on this, is simply to remove it from
22 these documents for now. And I think -- it's not
23 obvious to me what role the contractor would have
24 in the SEC process until we get a good feel for
25 what that's going to look like and our ability to

1 evaluate those petitions as -- and maybe -- maybe
2 we'll know that or have a -- start to have a feel
3 for that at the next meeting.

4 Clearly our role is very different in
5 that process than it is in these.

6 DR. MELIUS: My only concern about
7 delaying that decision -- and I don't think we
8 can make it today or --

9 DR. ZIEMER: Well, there's nothing our
10 contractor's going to do in the meantime on the
11 SEC, so --

12 DR. MELIUS: Right, right, right. Well,
13 the problem with delaying is there is, as Larry
14 pointed out, there's some timeliness issues
15 related to these petition reviews, and I don't
16 think we want to get in the position of, you
17 know, Larry -- NIOSH having ten, you know, SEC
18 recommendations ready for us and us saying well,
19 gee, we need a contractor to do this or we need
20 this assistance. And so I would hope certainly,
21 you know -- as may be -- hopefully by the next
22 meeting we can have a more complete discussion
23 and NIOSH'll have worked out much -- in much more
24 detail what will -- how it's -- the nature of its
25 recommendation, what the report's going to be

1 like, what will -- what kinds of information will
2 be given to -- to review and so forth.

3 MR. ELLIOTT: I think at the next
4 meeting we need to have an agenda item where we
5 present and walk through the procedures and
6 highlight, you know, those activities within the
7 procedures that are -- the Board is directly
8 involved in. You know, the notice of qualified
9 petitions. That's something the Board needs to
10 be aware of 'cause it's part of your notice.
11 Those things need to be shared with you in a
12 presentational format, which we have not done
13 yet. We would have put it on for this meeting,
14 but Katz couldn't stay for the whole meeting and
15 we had a full agenda, as well.

16 I also think if we don't have a research
17 report on a petition or two for you at the next
18 meeting, we need to have a shell of one so that
19 you can see what it is and give us input into it.

20 DR. ZIEMER: Yeah, you could do it in a
21 mock-up sort of --

22 MR. ELLIOTT: A mock-up, yeah.

23 DR. ZIEMER: So we can see what kind of
24 data we're going to be reviewing -- yeah. Good.

25 MR. ELLIOTT: This is -- we're also

1 required to have an evaluation plan, that's part
2 of the procedures. So you know, there's a --

3 DR. ZIEMER: That needs to be developed.

4 MR. ELLIOTT: -- litany of things here
5 that need to be attended to for your better
6 edification of the process.

7 MR. GRIFFON: And just -- just so people
8 do realize, it is in the contract. I mean I just
9 checked this with Jim Neton and it is, on page 7,
10 actually, of the Sanford Cohen & Associates
11 contract. It's no task, I agree, but if -- you
12 know, as we're thinking about this, if we do want
13 to create a task for something that they can
14 assist us with -- I think you're -- I mean -- and
15 we clearly said technical assistance. It wasn't
16 a audit kind of role. We knew that. But I think
17 the thinking was we might want some back-up on
18 certain issues that we felt uncomfortable
19 addressing. So just so people might want to look
20 at that and think about what a task might look
21 like, and as we go forward I think we need to
22 think about that.

23 DR. ZIEMER: Okay. So then going back
24 to the two documents, for the time being is it
25 agreeable that we simply remove that from the

1 documents and ask them to modify accordingly?
2 Without objection, we'll -- this'll be, for our
3 recorder, on the quality assurance plan at
4 section 3.0, second sentence, we would remove
5 "and SEC review", and on the conflict of interest
6 plan, page six under section 5.3, second
7 paragraph, remove the phrase "SEC petitions".
8 Tony?

9 DR. ANDRADE: Just a detail, but don't
10 forget the org chart on the next page, and also
11 the description of the con-- of the SEC program
12 manager.

13 DR. ZIEMER: The org chart -- yes -- has
14 an SEC petitions review manager.

15 DR. ANDRADE: Right.

16 DR. ZIEMER: And I don't know if they
17 have -- they could still have that in their
18 organization. Was -- was there one in the other
19 document?

20 DR. ROESSLER: (Off microphone) A
21 description of the manager in the...

22 (Pause)

23 DR. ZIEMER: Were those the only two
24 places, Tony?

25 DR. ANDRADE: Right, the roles and

1 responsibilities and the chart.

2 DR. ZIEMER: Thank you. In that
3 particular one, for example, on page seven, it
4 looks like a sampling of petitions that they're
5 reviewing, and this is something we, in any case,
6 have never specified.

7 Any other recommended changes for those
8 two documents? Yes, Richard?

9 MR. ESPINOSA: (Off microphone) Under
10 the cost projection accuracy --

11 DR. ZIEMER: Which document are you in?

12 MR. ESPINOSA: (Off microphone) QA plan.

13 DR. ZIEMER: QA plan, page?

14 MR. ESPINOSA: (Off microphone) Ten or
15 11. I'm just wondering if there's any way to add
16 maybe monthly reports to the Board or a quarterly
17 report to the Board.

18 DR. ZIEMER: On cost projections?

19 MR. ESPINOSA: (Off microphone) Yes.

20 DR. ZIEMER: Let me address that
21 separately because that's already being done and
22 I want to speak to that here in a moment. It's
23 probably not necessary to put it in here, but I
24 will address that in just a moment.

25 MR. ESPINOSA: (Off microphone) All

1 right. Thanks.

2 DR. ZIEMER: Any other changes?

3 MR. GRIFFON: Just --

4 DR. ZIEMER: Mark.

5 MR. GRIFFON: Just on the conflict of
6 interest document, I know that we had a
7 commitment during the presentation that the
8 conflicts of interest would be posted on the web
9 site. I wonder if maybe that could be included
10 in the -- and the web site location could be
11 also, you know, included. I'm not sure what
12 section it would go in.

13 DR. ZIEMER: Once these are approved.
14 You're talking about these -- this conflict of
15 interest plan?

16 MR. GRIFFON: Yeah, yeah. Yeah.

17 DR. ZIEMER: Once it's approved --

18 MR. ELLIOTT: I think he's referring to
19 their web site, and we'll add a hot link to our
20 to direct folks to their web site. Okay?

21 DR. ZIEMER: Yeah. On the issue that
22 Richard just raised, we have -- and they're
23 available for your perusal, they're sitting
24 behind Larry here -- the documents pertaining to
25 each of the four tasks. These incidentally are

1 not -- these are proprietary. They have cost
2 information in it so these documents are not
3 available to the public, but any of the Board
4 members can peruse these. They have the monthly
5 reports, progress reports, the individual monthly
6 billings, the amounts spent so far on each task,
7 the deliverables.

8 For example, here's task one, which is
9 the site profile review. And if you look in the
10 very front of this, it has all of the actions
11 taken by the contractor by date. Then there's a
12 section that lists the Board-approved proposal,
13 what the task is. There's various correspondence
14 relating to that particular task between the
15 contractor and, for example, NIOSH in this
16 particular case. There's -- well, there's some
17 procedures. There's proprietary information that
18 is -- the actual billings are in here. And
19 incidentally, when those monthly billings come
20 in, I see those. I have to approve those before
21 they're paid, so those -- those come in. There's
22 -- it shows -- the billing is broken down into
23 detail, which person -- which contractor person
24 accumulated so many hours and they're billed at a
25 certain rate, and travel, overhead and all those

1 things are in here. There are charts showing the
2 total spent on the tasks so far, the percent of
3 the award and so on. So all that detail's here
4 and we get -- that is updated monthly. That's
5 being provided -- it's being provided to me and
6 it's being provided to NIOSH, the person that
7 NIOSH has designated to track the expenditures in
8 the contract.

9 Are there any questions on that? And if
10 there's information that Board members want to
11 see monthly -- I mean any of that can be
12 distributed, but -- but for example, here's one
13 from July where I have signed off saying the
14 amounts claimed are reasonable and require -- I
15 have to certify that if there was a deliverable
16 that has been delivered, and then -- I'll show
17 you, Rich, 'cause you're right here -- it shows
18 all the previous vouchers and the amounts and
19 total billed to date against that task, percent
20 of the funds expended. Those are all tracked and
21 a detailed breakdown. So we have that on every
22 task, and it's -- yes.

23 MR. ELLIOTT: The procurement office
24 receives the billings and then they are sent to -
25 - to my office to Martha DiMuzio, who you've met.

1 She then provides a copy of those to Dr. Ziemer,
2 asking him to evaluate them and sign off on them,
3 or kick them back. We could, if you -- if it's
4 the Board's pleasure, we can have a presentation
5 on each task and the status of progress of
6 expenditures, not progress of work. Okay?
7 That's Sanford Cohen & Associates that should
8 present you progress on their work, but we can
9 give -- if you -- if it's your pleasure, we can
10 summarize for you in a report to the Board, and
11 it can be done either in a public presentation or
12 in a written summary --

13 DR. ZIEMER: For each meeting?

14 MR. ELLIOTT: For each meeting.

15 MR. ESPINOSA: (Off microphone) I'd just
16 -- I'd personally like just to see a general
17 overview of what's being done and --

18 DR. ZIEMER: Why don't we schedule that
19 as a regular part of each meeting. It'd probably
20 only take 15 minutes or so. Would that be
21 agreeable?

22 MR. ELLIOTT: That's fine.

23 DR. ZIEMER: Would the rest of the Board
24 like to have that information or --

25 MR. ESPINOSA: (Off microphone) So

1 moved.

2 DR. MELIUS: (Off microphone) Yeah.

3 MS. MUNN: I would hope that it would
4 only be a very, very high level overview. I for
5 one am -- I was impressed with the amount of
6 detail that was in the financial tracking of the
7 QA plan already, and I just --

8 DR. ZIEMER: I think it's going to be a
9 bird's eye view and that's what you're asking
10 for, Rich.

11 MS. MUNN: Yeah.

12 DR. ZIEMER: Where are we on -- where
13 are we on each task and --

14 MS. MUNN: Yeah.

15 DR. ZIEMER: It won't take too long.
16 We'll take it by consent that that will be
17 provided in the future. Thank you.

18 And then I think we'll keep -- these
19 will be here if you want to peruse these in
20 detail at the meetings, so I think Martha will --

21 MR. ELLIOTT: These will serve as a
22 reference -- set of reference documents for the
23 Board members. They are available at each Board
24 meeting. They will be maintained in a current
25 status, up to the point of, you know, whatever we

1 can arrive at before -- before we present to the
2 Board here, before we're at a Board meeting.

3 DR. ZIEMER: Thank you. Do we have
4 other items that we -- that the Chair has
5 overlooked or that --

6 MR. ESPINOSA: (Off microphone) There's
7 a couple of things that I'd just like to bring
8 up.

9 DR. ZIEMER: Yes, please.

10 MR. ESPINOSA: Number one, on a --
11 whenever we go to these sites, I'm just wondering
12 if we could get like a site overview of what the
13 site does and their -- it'd be especially helpful
14 to me when the public speaks that I'd kind of
15 know what they'd done.

16 DR. ZIEMER: Excellent suggestion. I
17 don't know what's planned for tomorrow, but it
18 certainly would be helpful to those that are
19 going to have an overview of the kinds of
20 activities the -- at least the primary facilities
21 that are on the site, what the site's role has
22 been in the past, that kind of thing.

23 MR. GRIFFON: I actually was talking
24 with Jim yesterday and I thought it would make a
25 lot of sense, up front on the agenda --

1 DR. ZIEMER: In the meeting.

2 MR. GRIFFON: -- if -- if you had not a
3 -- just a -- not just a historical operations
4 overview, but if a site profile's been completed
5 for where -- the location where we're at, sort of
6 present a summary of that, 'cause that might also
7 bring some questions up from the audience, you
8 know, later on in public comment time. So it
9 might be a way to -- for us to learn about the
10 site, but also to bring some questions --

11 DR. ZIEMER: And perhaps a description
12 of the main processes that have been done in the
13 past so that when workers refer to working on
14 some line or whatever that you can relate that to
15 a location or a process. I think it's a good
16 suggestion, Rich. I'm not sure how to implement
17 that. Do you know on the tour this time to what
18 extent they'll be given kind of an overview as --
19 at the front end of the tour?

20 MS. HOMER: (Off microphone) Well,
21 (Inaudible).

22 (Pause)

23 MS. HOMER: From my understanding, there
24 will be packets provided to each attendee that
25 include maps and things of that nature. There's

1 going to be a CD provided to each person. What
2 information is on that CD, I don't know. I know
3 that in Idaho Falls we'll be seeing a movie, and
4 then on the site out -- or on the trip out -- I'm
5 sure we can pose questions, as is -- norm.

6 DR. ZIEMER: Well, hopefully there'll be
7 some historical information, as well, in the
8 movie that sort of lays the groundwork -- why is
9 this site here, what has it done in the past,
10 what is it doing now. I think that --

11 MS. HOMER: And I suspect that's what's
12 in the packets of material we're getting. I know
13 that there'll be a map and there'll be a question
14 and answer period, as there always seems to be on
15 the tour.

16 DR. ZIEMER: But perhaps in the future -
17 - I think you're asking, Rich, in the future if
18 we might -- particularly if we go to a place like
19 Pinellas -- what did -- what went on here at this
20 plant. Yeah. Okay, thank you. Good suggestion.

21 Did you have another item?

22 MR. ESPINOSA: Yeah, on Dr. -- on the
23 outreach and the schedules -- on the outreach,
24 I'd like to see a schedule for the site profile.

25 And I'd also like to make sure that the area --

1 Department of Labor resource centers receive that
2 schedule, too. You know, I know there was an
3 outreach in Pantex and the Department of Labor
4 for New Mexico did not receive that.

5 DR. ZIEMER: What needs to be done here?
6 I'm -- can you flesh this out, Jim?

7 DR. NETON: Could I --

8 DR. ZIEMER: Yeah.

9 DR. NETON: I'd just like to address the
10 practicality of the request. I think it's a good
11 idea. The practicality is, though, that these --
12 these meetings get arranged fairly short order.
13 It takes a lot of negotiation with the local
14 union folks and we rarely have more than three to
15 four weeks' notice. So we can't put out, for
16 example, a schedule for the next six months. It
17 hasn't happened that way yet. We wish we could.

18 So the best we can do is to notify -- as soon as
19 we know -- you know, the affected people. But we
20 also do -- always notify Department of Labor, at
21 least the national level, that we're going to be
22 doing that and invite their participation -- if
23 they want. We don't want to force them into it.

24 It's not our call to require them to be there.
25 But we find it is helpful that Labor is there.

1 MR. ESPINOSA: Yeah, one of the -- one
2 of the reasons why I'm saying this and suggesting
3 this is there's outreach groups like the Los
4 Alamos POWs that would have been probably
5 instrumental -- and will be in the Los Alamos
6 outreach.

7 DR. NETON: Right, and I think we've
8 been coordinating with them. Mark Lewis -- I
9 don't know if everybody has met Mark yet. He is
10 -- he used to be a member of the union at
11 Portsmouth, has now joined ATL, one of the --
12 ORAU's contractors, as the lead on this issue.
13 And one of his jobs now is to go do pre-meetings
14 at sites. He will go to a place like Los Alamos,
15 knock on some doors, find out who the important
16 people are that can help him arrange these
17 meetings, and then we go about the business of
18 finalizing. So we're doing a lot of -- a lot
19 better job of groundwork up front now than we did
20 say three or four months ago.

21 DR. ZIEMER: Okay. Thank you.

22 MR. ESPINOSA: Thank you.

23 DR. ZIEMER: Other items? Jim?

24 DR. MELIUS: I have a couple of other
25 questions. One is a question on -- back to our -

1 - our contractor. Presumably at our -- by our
2 next meeting or before our next meeting, they
3 will have done -- completed some of the site
4 profile reviews. What is our procedure for those
5 being shared with the Board, as well as being
6 presented to the Board? Have we sort of decided
7 on a format and an approach for doing that?

8 DR. ZIEMER: We do not have a set
9 procedure for that. It would -- I think on the -
10 - on the site profiles, I believe it's in order
11 for us to get a copy of the draft in advance, is
12 it not? Can that be done? I'm asking this from
13 a legal point of view.

14 DR. NETON: Well, advance to the extent
15 that -- and Dr. Ziemer, you were a part of this
16 conversation we had with Sanford Cohen -- that
17 NIOSH would be first afforded a fact-- a review
18 for factual accuracy of the draft before it was
19 issued to the Board. At the time it's issued to
20 the Board I think it becomes a public -- public
21 document, and so we just --

22 DR. ZIEMER: Well, that was my question.
23 Is it public or predecisional if we're -- if
24 it's distributed to us for review prior to a
25 meeting?

1 DR. NETON: Okay, Liz Homoki sitting
2 next to me says it's predecisional, so I guess
3 it's not necessarily publicly --

4 DR. ZIEMER: Until we adopt it, it's --

5 DR. NETON: -- available until you adopt
6 it. But once it was -- well --

7 DR. ZIEMER: Once it's on the floor at
8 the Board meeting, it becomes --

9 DR. NETON: Right, then I guess that's
10 your option then on how to -- how to proceed with
11 that predecisional draft --

12 DR. ZIEMER: Right.

13 DR. NETON: -- whether it would be a
14 closed session or just have it vetted at a public
15 session.

16 DR. ZIEMER: Yeah. Well, let me kind of
17 bounce your question back to the full Board, Jim,
18 and that is how does the Board wish to proceed on
19 this? It would make sense to me that we got some
20 kind of a draft of the proposed report at some
21 point when -- when the contractor believes it's
22 ready. They will have done a reality check with
23 NIOSH on factual accuracy at that point. Tony?

24 DR. ANDRADE: I think I would just
25 suggest -- I guess to start the conversation --

1 that we follow a parallel path. I think it is
2 wholly appropriate that NIOSH reviews it for
3 factual accuracy. But after that, the review
4 itself should be considered by the entire Board
5 during a closed session.

6 DR. ZIEMER: I don't know if there's any
7 privacy issues that would allow us to do it in a
8 pri-- in a closed session. My impression is that
9 the reason for the closed session was --

10 DR. ANDRADE: Was Privacy Act.

11 DR. ZIEMER: -- was Privacy Act issues
12 on individual cases. I don't think that would be
13 the case for a site profile, would it?

14 MS. HOMOKI-TITUS: (Off microphone) I
15 can't imagine that it would be.

16 DR. ZIEMER: So it --

17 DR. ANDRADE: Oh, I can -- I can
18 imagine.

19 DR. ZIEMER: You can imagine?

20 DR. ANDRADE: Yes, of course, especially
21 if they're going to do interviews with site
22 personnel.

23 MS. HOMOKI-TITUS: (Off microphone) But
24 I'm going to have to see (Inaudible).

25 DR. NETON: The only issue that I could

1 foresee is that in order for the Board to
2 understand what has been completely done, as Tony
3 suggests, is maybe some Privacy Act information
4 may need to be discussed to understand some
5 concerns or issues the Board might raise. I mean
6 that's a possibility. I don't know.

7 DR. ZIEMER: Well, what would have to
8 happen, I think, in reality is that once the
9 draft document was ready, if the contractor had
10 some concerns that in discussing this they had to
11 identify individuals from whom -- I don't know if
12 it's individuals from whom they obtained
13 information had to be disclosed or what -- then
14 perhaps it could be in private session.
15 Otherwise, I think it's got to be in the open
16 session, as far as I can understand it. Robert?

17 MR. PRESLEY: If there are areas in
18 there where we would have to use a name or a --
19 or a -- of a person that they went through, could
20 you not leave that out and put the site that -- I
21 mean the site's not going to be anything.

22 DR. ZIEMER: I mean it's going to be --
23 it's going to be an evaluation of the site
24 profile, so I -- the report itself -- it's hard
25 for me to envision why it would necessarily bring

1 out individual issues. Can -- can you think of
2 any? I mean --

3 MR. ELLIOTT: When we do our work and we
4 consult with people -- like if you look at
5 Bethlehem Steel, or maybe that's not a good one;
6 what's the Bridgeport Brass one -- we use
7 personal communication. And if we cannot get a
8 release from the individual that we talked to,
9 then that's the way it is couched, a personal
10 communication. I would hope that your contractor
11 would use some similar approach to either get a
12 release or waiver from the people that they talk
13 to so that their name could be used as a
14 reference, or it is listed as a personal
15 communication. Otherwise, I -- you know, I'm at
16 a loss, too, as to -- unless -- unless there's a
17 -- the only other thing I could think of, as I
18 was sitting here listening to the discussion,
19 unless there is a document that is found by your
20 contractor that we had not discovered that may
21 have personal dose data in it, you know, personal
22 identifiable information in it that would -- in
23 that case, I'd hope they would redact it for
24 public consumption.

25 DR. MELIUS: But most likely they're

1 just going to reference it.

2 MR. ELLIOTT: Most likely they're going
3 to reference it, so --

4 DR. MELIUS: So it's not going to be --
5 yeah.

6 DR. ZIEMER: Yeah. So my sense of it is
7 that it's -- it comes to the Board so we have a
8 chance to see it before our meeting, but it is
9 part of the open meeting.

10 DR. MELIUS: This -- the procedure --
11 and again, I'm concerned about appearances here,
12 that -- at the time it comes in for this fact-
13 checking by NIOSH, do you get a copy of it, Paul,
14 or is it just --

15 DR. ZIEMER: No.

16 DR. MELIUS: Is there going to be
17 documentation of what changes are ask-- what --
18 what if there's a dispute between -- about the
19 facts between the contractor and NIOSH? Is --
20 how do we get that resolved?

21 DR. ZIEMER: Actually I think maybe Jim
22 -- can you answer --

23 DR. NETON: Yeah, I think -- I think
24 that, knowing -- working with SC&A thus far, I'm
25 very certain there will be some documentation if

1 there were any changes to some record file. I
2 mean that's going to happen. I don't think
3 there'd be any problem with -- with Dr. Ziemer
4 receiving an advanced copy, I suppose, while
5 we're doing a factual accuracy check, just so a
6 paper trail could be followed as to what -- what
7 had changed. But really, this is -- this -- SC&A
8 is under no obligation to change anything at all.

9 I mean all -- all we're doing is be able to
10 provide comments back as to the factual accuracy.

11 If they disagree that it -- they disagree that
12 this is the way it's going to be, that's their
13 prerogative. We have no control over their
14 ability to edit the document at all. It's just
15 going to be our comments back them on --

16 DR. ZIEMER: They would just comment
17 that we don't agree that you've -- that you've --

18 MR. ELLIOTT: I think --

19 DR. ZIEMER: -- characterized this
20 correctly or whatever.

21 MR. ELLIOTT: You know, we'd play an
22 untenable role here, and I would hope that it's
23 the Board's pleasure and insistence that someone
24 on this Board -- and I think this was discussed
25 Monday afternoon -- see the NIOSH comments for

1 factual accuracy and clarification that were
2 given, and understand then from that point of
3 view, you know, what changes were occur-- took
4 effect or what didn't take effect, you know.

5 DR. MELIUS: Yes, no, that -- that's --

6 DR. ZIEMER: So it's tracking both sides

7 --

8 MR. ELLIOTT: Yeah.

9 DR. ZIEMER: -- of the issue.

10 DR. MELIUS: Right, and so if a copy
11 came to you, Paul --

12 DR. ZIEMER: Then we would also want a
13 copy of the comments.

14 DR. MELIUS: -- and you'd get a copy of
15 the -- or you know, whenever -- whatever the
16 timing is, I don't care, but the -- that way
17 you're in the -- the report's to the Board. It's
18 gone to NIOSH to -- you know, for this factual
19 check, which is --

20 DR. ZIEMER: Sure.

21 DR. MELIUS: -- which is appropriate,
22 and then -- you know, if there is -- in fact it
23 may help resolve any -- any issues or what-- and
24 -- 'cause we are going to decide what can be
25 presented and so forth, and we certainly don't

1 want to be in the position of sort of
2 point/counterpoint or, you know, that, I don't
3 think.

4 DR. ZIEMER: Yeah.

5 DR. MELIUS: And so at the same time
6 that says yeah, there is a paper --

7 DR. ZIEMER: There's a paper trail.

8 DR. MELIUS: -- trail or whatever you
9 want to call it with that and it protects
10 everybody involved.

11 DR. ZIEMER: I think it's a good
12 suggestion and I'm certainly willing to do it
13 that way if there's no objection on the part of
14 the Board.

15 MR. ELLIOTT: I don't even see any
16 reason why our comments wouldn't become part of
17 the public record. I would hope that they would.

18 DR. ZIEMER: Sure.

19 DR. NETON: I might just add one thing.
20 In our discussion on this with SC&A where Dr.
21 Ziemer was involved, John Mauro agreed to take on
22 the task of -- of writing this up as an internal
23 procedure within SC&A to improve the transparency
24 of the whole process so it didn't appear to be an
25 arbitrary process. And I haven't seen that yet,

1 but I know that he was -- he volunteered to do
2 that, so we might ask him -- the Board might ask
3 to see if that -- if that's done.

4 DR. MELIUS: I have one other -- I guess
5 question or comment, would be if -- if NIOSH is
6 going to be ready at the next meeting to present
7 us with an evaluation on an SEC petition, would
8 it -- would it -- and I guess this is my
9 question. Would it be helpful for us to have a
10 working group set up to -- to interface with
11 NIOSH and staff between now and the next meeting
12 so that we get -- you know, maybe make that --
13 our evaluation of that petition go easier when it
14 is presented to -- to the Board? There are going
15 -- I mean there's a number of --

16 DR. ZIEMER: Are we likely to be
17 evaluating a petition at the next meeting, or --

18 MR. ELLIOTT: You're -- I -- this is not
19 promissory. Okay? I certainly expect you're
20 going to have an evaluation plan to look at.

21 DR. ZIEMER: Yeah, that's --

22 MR. ELLIOTT: I would -- I would also
23 hope that we might have one or two or -- I don't
24 know how many, maybe at least one -- class
25 petition evaluation report for you to look at.

1 So you know, we're -- we're working very hard
2 trying to push these things through, at the same
3 time -- at the cost of not bringing the Board
4 along fast enough, too. I recognize that. So if
5 you want a working group, I'll work -- I'm
6 willing to work with y'all.

7 DR. ZIEMER: This would -- this would
8 mean that whatever proposed SEC petition is ready
9 to go would have to be ready for a working group
10 prior to a meeting. I suppose it could be the
11 day before, but we have a day set aside already
12 for our subcommittee, so then we're getting --
13 we're moving the timetable back. But we can
14 certainly set up a working group on a standby
15 basis, if the Board wishes, so that, if needed,
16 they could be marshaled into action.

17 DR. MELIUS: That -- that's really what
18 I --

19 DR. ZIEMER: Is that your suggestion?

20 DR. MELIUS: -- think is -- and -- yeah.

21 MR. ELLIOTT: They could certainly meet
22 separately from the subcommittee on the same day
23 if that's, you know, necessary.

24 DR. MELIUS: That working group would be
25 sort of contingent on the -- you know, whether or

1 not you're ready -- if you're going to be ready
2 or not.

3 MR. ELLIOTT: It wouldn't be in the same
4 room --

5 DR. ZIEMER: However -- however, we are
6 envisioning that at our next meeting that we will
7 be reviewing 20 cases as a full Board in closed
8 session.

9 MR. PRESLEY: (Off microphone) That's
10 right.

11 DR. ZIEMER: So unless we have a fourth
12 day set aside, we're -- on the other hand, a
13 working group can also work by phone, if
14 necessary, if they have something to look at.
15 Does the Board wish to have a working group on --
16 sort of on standby for this activity if -- if
17 necessary?

18 MR. ESPINOSA: I don't think that'd be a
19 bad idea.

20 MR. PRESLEY: Question.

21 DR. ZIEMER: I'm -- yeah.

22 MR. PRESLEY: Could -- we're supposed to
23 get a plan prior. Would it be possible for us to
24 get a copy of the plan and us go through that,
25 and let's go through -- if -- if we do get some

1 reports ready to go, go through them. And if we
2 need a working group, then come up with a working
3 group after we see how much detail and work this
4 is going to be. Would it be possible for us to
5 get that evaluation prior to so that we can all
6 look at that?

7 DR. ZIEMER: Evaluate the plan itself.

8 DR. MELIUS: But I think we have to
9 establish the working group at a meeting, so we
10 have to -- if we're going to do it between now --

11 MR. PRESLEY: It could be done -- it
12 could be done at the next meeting.

13 DR. ZIEMER: The working group could
14 look at the plan, though, is what he -- what I
15 think is --

16 MR. PRESLEY: Do you want the working
17 group to look at the plan?

18 DR. MELIUS: Look at the plan, and then
19 if necessary or appropriate, yeah.

20 MR. ELLIOTT: I don't see a problem with
21 that at all. I think that's -- makes a lot of
22 sense for us to get an evaluation plan to you so
23 that you can see what that looks like -- and
24 that's nothing more than telling you where we're
25 going to look, which rocks we're looking under

1 and how -- you know, how far we're going and why
2 -- you know, what we're --

3 DR. ZIEMER: We could --

4 MR. ELLIOTT: -- using in that eval--

5 DR. ZIEMER: -- we could set up --

6 MR. ELLIOTT: -- in that research.

7 DR. ZIEMER: -- a working group of three
8 or four. They'd be on a standby basis. They'd
9 have to establish a date based on what happens at
10 NIOSH. There appears to be -- without taking a
11 formal vote, there appears to be support for the
12 idea of having a working group on call. I now
13 then will ask for volunteers. We need at least
14 three people to be in the working group.

15 DR. MELIUS: Henry, Roy, Mike --

16 MR. ESPINOSA: I second.

17 DR. ZIEMER: You're volunteering for
18 them. Okay, Rich has volunteered --

19 DR. MELIUS: I'll do it, though.

20 DR. ZIEMER: -- Wanda has volunteered,
21 Jim has volunteered, and we can add one more --
22 Bob Presley. We've got four people.

23 MS. HOMER: That's Rich, Jim, Wanda and
24 Bob?

25 DR. ZIEMER: Rich Espinosa, Wanda Munn,

1 Jim Melius, Robert Presley. Their task will be
2 to evaluate and make a recommendation on the
3 evaluation procedure -- procedures --

4 MR. ELLIOTT: Plan.

5 DR. ZIEMER: -- plan, evaluation plan,
6 and if necessary on a petition, if it is in a
7 state for such review. Let me ask, Robert, will
8 you be willing to serve as the coordinator and
9 make sure that the -- you -- the four of you come
10 up with a common time, you either share it by e-
11 mail or phone, conference call, whatever,
12 coordinate time and effort and make sure
13 everybody's got the documents, if that's
14 agreeable?

15 MR. PRESLEY: I'll do that.

16 DR. ZIEMER: Thank you. And then you'll
17 report back to the Board at our next meeting.
18 Thank you.

19 MR. ELLIOTT: If I may, just so
20 everybody understands, could we give you an
21 evaluation plan today? No. If we had qualified
22 a petition, were we ready to give you an
23 evaluation plan? On short order thereafter.
24 Okay? But we've got to qualify the petition
25 first, then come -- the ne-- first things first.

1 Then the next thing is give you an evaluation
2 plan.

3 DR. ZIEMER: Okay. Thank you. Other
4 comments, suggestions, recommendations?

5 (No responses)

6 DR. ZIEMER: Anything for the good of
7 the order?

8 MR. ESPINOSA: Motion to adjourn?

9 DR. ZIEMER: Wait, I -- before you
10 adjourn, Cori has a final comment.

11 MS. HOMER: Very quickly, and I'm sorry
12 to not give you this information earlier, for
13 those who are attending the tour, a reminder to
14 bring photo ID and cash for lunch. We'll be
15 eating in the lunchroom.

16 DR. ZIEMER: Thank you. Mark, another
17 comment?

18 MR. GRIFFON: And it's probably a little
19 late in the day to bring this one up, but the --
20 the site profile reviews -- I mean I'm going back
21 to yesterday's presentation. If -- if SCA is
22 going to give us a report, we still have that
23 question of -- the task says final report, and
24 you know, we had some dialogue yesterday about,
25 you know, could we make this an interim report

1 because they haven't had access and they might
2 want to go...

3 DR. ZIEMER: Mark, I interpret that more
4 as a heads-up issue of concern. I don't think
5 they're at the point where they're saying that
6 they want us to change the task right now. I --
7 that was -- would have been my understanding of
8 it, because now the access issue has pretty well
9 been taken care of and they're moving ahead. So
10 unless they come back to us and say we really
11 aren't going to get there --

12 MR. GRIFFON: My under-- my
13 understanding was they felt like they were up
14 against some deliverables, but if they delivered
15 what they have now, it would be perceived as the
16 final report and therefore there'd be no chance
17 to go further and -- you know, I -- I just -- I
18 don't know if that's an issue or not an issue
19 or...

20 DR. ZIEMER: My interpretation of what
21 they said was that they're giving us a heads-up
22 that they might get to a point where they feel
23 like they -- they have not finished but can't go
24 any further. I don't believe they're there yet.

25 DR. MELIUS: Yeah, that --

1 DR. ZIEMER: How did other --

2 DR. MELIUS: My -- my -- that was my
3 recollection, too, at least for the ones that are
4 -- had the earliest deliverables, I believe --
5 Savannah River, Mallinckrodt, Bethlehem, if --

6 DR. ZIEMER: I think they're okay on
7 those.

8 DR. MELIUS: -- if those issues were
9 resolved for --

10 DR. ZIEMER: Right.

11 DR. MELIUS: -- and that we just have to
12 see where things go with some of these other
13 issues later on.

14 DR. ZIEMER: They were kind of laying
15 the groundwork for coming back to us and -- and
16 saying we can't go as far as we thought we wanted
17 to, is how I understood it. I'm -- I don't know
18 that there's any action that we could take now
19 that would --

20 MR. GRIFFON: Okay. I just --

21 DR. ZIEMER: Until they --

22 MR. GRIFFON: Maybe in the future we --
23 I --

24 DR. ZIEMER: We may have to do something
25 in the future, and I think he was --

1 MR. GRIFFON: Yeah, and I'm thinking
2 about how -- how the Board is going to interface
3 --

4 DR. ZIEMER: I think he didn't want to
5 hit us cold with that at some point down the
6 line.

7 MR. GRIFFON: Okay. But I think in the
8 future we may need on there --

9 DR. ZIEMER: We may need to define what
10 we think is a final report.

11 MR. GRIFFON: And -- and is within the -
12 - I mean we may have to make some interpretations
13 as a Board as to the --

14 DR. ZIEMER: Yes.

15 MR. GRIFFON: -- technical scope.

16 DR. ZIEMER: Yes.

17 MR. GRIFFON: Right.

18 DR. ZIEMER: Yes.

19 MR. GRIFFON: All right. I guess we'll
20 leave it --

21 DR. ZIEMER: Yeah, good comment. Other
22 items?

23 (No responses)

24 DR. ZIEMER: If not, we stand adjourned.
25 Thank you very much.

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(Whereupon, the meeting was adjourned at
3:10 p.m.)

