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P R O C E E D I N G S

(8:30 a.m.)

WELCOME

DR. ZIEMER: I'll declare the Advisory Board on Radiation and Worker Health back in session for the second day of this meeting. We begin our discussions this morning with the review of site profile development. Jim is -- Jim Neton is going to lead us in that. Jim, the podium is yours.

SITE PROFILE DEVELOPMENT - STATUS

DR. NETON: Good morning. The good news is -- or bad news is you have to listen to me talk again. The good news is this my last formal talk of the session. The good news is it's also not directly after lunch, which I seem to be scheduled frequently to do presentation, so hopefully we can all stay awake.

Site profile development status, this is something that was requested at the last Board meeting in Cincinnati, that NIOSH provide an update as to where we're at in this process, so that's what I'm going to go over here for a few minutes this morning.

Just a brief overview of what we mean by site profile, and honestly that definition has

somewhat morphed over time to include additional items. The original intent of the site profile definition was to include descriptions of the internal and external dosimetry programs, external data that include -- for the external data, that would include dosimetry change-out frequency, the lower limits of detection for those devices, the assumed quality factors that were used to historically at the site for neutrons or -- neutrons. In the internal dosimetry area it would include the type and frequency of the monitoring performed, the limit of detection, the rate of nuclide monitoring and description of techniques used.

In the area of environmental data, we relied primarily on collection of annual reports for the most common source of that information. And more often than not, we're looking at environmental dosimeters that are placed about the site in strategic locations to try to monitor what -- you know, what the exposures were outside of the facilities. That does not include just the perimeter fence monitoring devices, but also those that are in common areas outside the buildings. So in many cases you do get a nice little grid of the

environmental dose that was delivered at the site during specified time periods.

The air samples also are of primary interest. One interesting thing about air samples we're finding is that sites tend to collect an air sample and then put that on a detector and measure the periodic table, and so we end up with a large number of radionuclides that have been determined and so it makes our internal dose assessment or reconstruction somewhat cumbersome. But as you saw Grady Calhoun indicate yesterday, we're making some assumptions now where we'll take the worst case radionuclide that could have been there and use that, at least as a first cut, to determine what the environmental dose would have been. So we're moving in that direction to optimize that process.

The last bullet here is that environmental data must be used in all cases that have a likely probability of causation of less than 50 percent. We need to keep pulling the string, as we say, on that dose the person would receive. So if their internal dose and their external dose was less than 50, we need to look at the environmental dose to see if that would put them over the top as far as compensation would be concerned.

Diagnostic X-rays includes the frequency of the examinations, the type examination, the machine settings, entrance skin dose, those sort of things. In the early days -- early days; six, eight months ago -- we actually tried to obtain the X-rays themselves, and it became extremely cumbersome for the sites to pull these out. It turns out X-rays are stored in a separate department, in the medical department, versus bioassay records which tend to be stored in the radiological departments. So to avoid a lot of effort, we've come up with an approach that would -- if a site would profile their monitoring programs. In other words, tell us over time how often you required X-rays for certain classes of people, what types of machines you were using and give us a rough idea of what the dose is, we would add that in, at the beginning, and just assume that the person received that as a first cut. And that's been working pretty well, as we'll talk about later. I think we've got a good number of the sites covered on this approach. That's not to say that if we did need it we wouldn't go back and request additional -- the real X-ray profile for that person.

I did say we've got a lot of data, but we typically do not have all of it. We normally get

some portion of it, but we're -- that gap is closing very rapidly. We're fairly pleased with where we're at with the X-ray profile.

Again, in our rule the X-rays would have had to have been received as a condition of employment to be considered. That is, if you were an asbestos worker and you had to have an annual chest X-ray to be an asbestos worker, then that would be included in your reconstruction. It turns out that many claimants don't really know whether it was required or not, and being claimant-friendly, if they don't know -- if there's any evidence at all that it was required -- we'll just add it in there. In fact, in many cases with a very, very low dose, one can add it in there and it doesn't really make a difference in the probability of causation calculation, so we're not going to split hairs over those types.

And again, just like environmental dose, diagnostic X-rays must be included in all case that are less than 50 percent. Again, to pull the thread all the way to give the claimant the benefit of the doubt for all possible sources of doses that they could have received.

This was not originally included in our definition of site profile information, but now

we've added this to the database, which is the area monitoring, process descriptions and source terms. So in a sense now, all site profile information is everything that is non-personnel monitoring related. If it's not a TLD badge, a film badge or a urine sample -- some sample that was taken directly on the person -- it is now, by definition, considered to be site profile data. It makes some sense when you think about it. And as I mentioned earlier, it includes air monitoring, TLD's, process descriptions, that type of information. It's normally not required to be used unless we had no personnel monitoring data, so in that sense it's somewhat different than the big four -- internal, external, environmental and medical. We don't necessarily have to use this type of information.

And we don't have much of this information right now. Some sites we do have air monitoring data -- the Fernald site comes to mind. We've got a pretty complete picture of their monitoring data since 1952 at that facility. But this is the type of information that we're hoping and encouraging our contractor to go out and try to fill in for us.

Okay, what is the status. We've got data from 15 of the major DOE facilities in-house right

now. Not complete sets, but we have data -- some piece of data for the site profiles from 15 different facilities. None of the sites have submitted everything we need. There are gaps in every one of these things, as I indicated. But we are building a shared computer directory, what we call the OCAS drive, the O drive, that's out there that has about -- I think I said yesterday about ten gigabytes* of data. It's a little bit misleading. Spread sheets and that sort of thing don't take up much room. But the majority of that information is filled up with reports that we've collected and assembled -- environmental reports tend to be voluminous.

We are digitizing them, making electronic images of all those reports so they're available to all dose reconstructors -- essentially instantaneously, at the same time. We are working with ORAU to create a web-based interface for this so these dose reconstructors that are distributed throughout the country will have access to the same information that we have in our database at NIOSH. So we're hoping this is going to become a very useful tool as time moves forward.

This is a snapshot as of -- I think last

week, end of last week sometime, or whenever I had to finalize this presentation -- sometime last week, of those 15 sites that I mentioned. And you can see that a lot of the blanks are filled in. Clearly in the environmental area, we're lacking. We're obtaining a lot of the environmental data off of the web sites. After 9/11, though, a number of the sites pulled a lot of their databases and environmental data went with it, but we're slowly adding back. We're applying for rights to those data files and such, and it is getting better.

I mentioned medical doses. We have a large number of the sites covered.

External is probably the area where we've got the most information. Those tend to have been characterized pretty well historically. Usually you can find at a site some document that someone wrote that describe the history of the external monitoring program. They typically didn't change much over the history of the site. They all started off with film badges back in 1950's, and many sites used the same badges -- the ORAU -- the Oak Ridge badge or the INEEL badge, those kind of things, and the degree of filtration may have changed. And then maybe in the eighties they all switched to thermoluminescent

dosimeters, so we kind of got a clue on that. Neutron dosimetry is a little bit less certain than the external information.

The bioassay, the internal dosimetry area, is somewhat difficult. We are trying to fill it in. We don't have a complete picture really, even though it will say '50 to the present here, we feel we have some gaps in some of the more exotic type analyses that are done. The routine stuff I think we've got a handle on. But a number of sites every once in a while would have an incident and would take some samples that were unique, maybe ten samples of a kind, something like actinium 227, which you rarely encounter. And so we don't feel we've got a full picture there.

But nonetheless, all these data are being entered into a database. We have two people right now working full time doing this for us. ORAU is going to pick up that burden shortly and is actually working with those people as we speak to populate this database -- or refine it, and to pedigree it, so to speak. The information we're receiving is what we've been told. We've already found in at least one instance that it's either wrong or misleading, so we need to go through -- we feel

obligated to go through and establish the pedigree of the information that's been provided to us. And that's a fairly significant challenge.

MR. PRESLEY: Jim, can I ask a question, please?

DR. NETON: Yes.

MR. PRESLEY: Bob Presley. Is there any way that the new contractor can go directly to the site, rather than have to go through DOE?

DR. NETON: We're working on that. As far as requesting -- DOE is still requiring us to go through the DOE operations officers to request the individual -- or the personnel monitoring data. But we are pursuing the option of our contractor -- with us, in the beginning at least -- to visit the sites and work with them directly. And I think DOE is receptive to that. Once we established that relationship, we would have to notify them, let them know that we're going there, but that shouldn't be a problem. Today's a good example. We have people up at Los Alamos reviewing records. We just notified the DOE operations that we intended to do that. There was no problem, and then we just work directly with the sites. I see no reason why the contractor -- our contractor couldn't do that with us. The

trick is getting time.

MR. ELLIOTT: I think the completion of the MOU is going to help us in this regard considerably, once we get that put in place.

DR. NETON: A lot of that has to do with how much time you're really requiring of the site. I mean if one wants to go in there and do a month-long data capture effort, I think we might meet some more resistance. It all comes down to funding, really, in my mind, is how much of their contractors' resources are we going to use up and is there funding available to accomplish that. It's been a major issue for a while.

Okay, I've got some little pretty pictures here that actually sort of summarize the information that was on that chart. I have to explain this percent complete. I think it's somewhat misleading. All this really means is that we have -- we took the monitoring history of the site. If the site operated from 1952 to 1988, that's X number of years, and how many of those years did we have external data covered. That doesn't mean that we pedigreed it, that we really believe it all, but we at least have received from DOE some information for those years.

So that being said, you can see that we do have many of the sites covered. There are still some gaps, notably those out in California, maybe some of those located in Tennessee and maybe the Kentucky/Ohio area. We're working on that. The DOE is very aware of our gaps. We worked with these site profiles directly with the Office of Worker Advocacy. I find that they've been supportive. They've arranged site visits for us. I've gone out with the Office of Worker Advocacy to encourage them to provide this information, to determine why if we can't get it, what's the shortfall. So I'm pleased with their cooperation from OWA, at least.

MR. GRIFFON: Jim, just a clarification on that. When you say external -- when you say dosimetry information or -- I wonder are you sliding in there or -- either one, external dosimetry data, you mean that the entire profile of --

DR. NETON: Just the badge reads, the TLD reads.

MR. GRIFFON: A badge -- badge reads, but also, you know, the percent complete -- also the profile of the frequency of monitoring --

DR. NETON: Yes. Right, yeah.

MR. GRIFFON: -- and the -- those sort of

things --

DR. NETON: Yeah, we have a handle on the frequency of badge exchange and the lower limit of detection of the badge, and some idea of what the capability of the badges were. Was it a four-element filtration badge or did it have an open window/closed window, those kind -- types of characteristics. In some cases we have very good knowledge of the energy dependence and the angular dependence, that kind of thing.

MR. ELLIOTT: Jim, I'd like to make a comment on this slide, too, 'cause I think it is somewhat misleading in the fact that for K-25 in Portsmouth we have it at NIOSH in the HERB research branch holdings, but may not have been fully incorporated into the site profile data yet. So like for K-25, we do have a lot of this external dose -- dosimetry information. We have a lot of X-ray information. Same way for Portsmouth, we have a lot of dose information -- dosimetry information, area monitoring data, but we don't have it incorporated into the profile yet.

DR. NETON: Right. This is really a snapshot of what we've requested from DOE. What happened is we worked with the Office of Worker

Advocacy to establish what we needed, an e-mail went out -- an all-points bulletin to all the operations office saying please provide NIOSH the following, and this is what the DOE has actually provided us. And Larry's right, the HERB -- Health-related Energy Research Branch -- has a number of holdings, but I also wanted to get them directly from DOE. Things may have changed, been reorganized. A newer document may have been created, which has happened. So we're holding out that DOE will have something supplemental. In some cases -- oh, I'm sorry.

DR. ANDERSON: Yeah. How do you determine completeness?

DR. NETON: Again, it's a rough number, and these are relative terms, but I wouldn't say that we're 95 percent complete with the profile. This is -- the DOE has sent us 95 percent of the -- we have 95 percent of the operating history of the plant covered for a profile with regards to the badge type, the lower limit of detection, the frequency of exchange, that sort of stuff. So we have a pretty good idea for 95 percent of the operating history of the site what those were.

I suspect in Oregon we're missing some of the early days when they were the metallurgical

laboratory and -- who knows. We may find that yet. But again, it doesn't mean that we're 95 percent done.

I was almost reluctant to show this. It raises more questions than it's really worth, but --

DR. ANDERSON: Qualitatively --

DR. NETON: -- I thought the pictures would be nice. I could always go back to the other one, but I'll just slough through these.

The same kind of thing here. I guess it just shows you the overwhelming lack of completeness here in the internal area.

DR. ZIEMER: Does the internal include whole body counting, as well --

DR. NETON: Yes.

DR. ZIEMER: -- as bioassay?

DR. NETON: We have in vivo/in vitro samples. Well, again, you know, we're definitely behind the eight-ball here. There's some issues here. Internal monitoring data, by nature, has not been as nicely categorized as it's harder to get your hands around. We have some good stuff out there. I think -- again this is some -- I know for Idaho we've got some historical documentation out there that Larry alluded to that goes through -- I

think we have a complete set of procedures that they used, but again, you know, we don't have any feedback from Idaho directly on anything -- recent information.

Medical X-ray data, as I mentioned, it's getting better, especially since we were only looking for a profile like what kind of X-ray machine did they have, what kind of shots were they taking, that sort of thing. And so for some sites, like Hanford, we've actually got it -- I don't know if Hanford's on here, but we've got it figured out that -- we're better than that now. Recently we've got some information where we're actually forming an algorithm where we can just punch in the year and -- well, the year, and figure out what the average X-ray dose was for that facility. There's an algorithm we can use based on the settings and the instruments and stuff, so it's actually coming along nicely. We've got someone working on that program.

Environmental data is pretty consistent with what I showed you. It's a lot of blanks. Hanford has very good environmental reports out on the web. We're using those to the extent we can. I know Savannah River just sent us a bunch, so that's not indicated here. I think we've got like 1989 through

the present covered at Savannah River right now. We're missing the early years, and as you go back in time the environmental reports are not nearly as complete as they are today, but we're working on -- we're doing our best to try to fill in those blanks.

Data obtained from atomic weapons employers, we talked about this a little bit yesterday. Highly variable from site to site, as we discussed. It ranges from no data to -- as we saw, we had two years of personnel monitoring data at one of the sites. We have yet to find all this information, of course, but so we're holding out hope that we may run into the treasure trove of data. EML is one of our hopes.

Area monitoring data is sometimes available. We've found some area TLD's out there, process descriptions and source terms are available. So it's kind of all over the board. We're really in our infancy here of trying to pull this stuff together.

We've got some data capture efforts. We kind of previewed this yesterday. We went down to the Oak Ridge vault and pulled out -- I forget, it was 15, 16 boxes worth of records. Those are scanned out on our intranet site right now,

available for any dose reconstructionist to use. I think it covers about 12 to 15 different AWE's. So we're intending to go out to the Environmental Measurements Laboratory and search those files. This is not really an AWE. I'm not sure why I put it on there, but it's something that's going on today to look at records at Los Alamos.

And I think that's really all I have to share with you this morning. If there's any other questions that people have, I'd be glad to answer.

DR. ZIEMER: Let me start with a couple of questions, and then others may have some.

On the environmental data, are you able to get both upwind and downwind air samples so you can actually determine the site contribution to an air sample?

DR. NETON: Well, we were not looking at -- we're getting distribution of air samples about the site. We honestly haven't looked at them in terms of their -- the upwind/downwind directions. We were actually --

DR. ZIEMER: Presumably you have that then.

DR. NETON: Yeah. But we're looking more at where the person was located in relation to where the air sample was taken and kind of assuming that

was the representative air sample environment for the person. It's like --

DR. ZIEMER: I guess my question is is that air sample representative of the contribution from the site. You see --

DR. NETON: Oh, I see what you're saying. Yeah.

DR. ZIEMER: It may not. I just wondered how you're handling that. It may be premature to ask that.

DR. NETON: Well, actually we were just including it as if it were --

DR. ZIEMER: As if it were --

DR. NETON: -- from the site, which would be a claimant-favorable approach.

DR. ZIEMER: It certainly would. Okay. On early diagnostic X-rays, even if you have the machine settings, are you able also to get information on beam filtration?

DR. NETON: Yeah, yeah.

DR. ZIEMER: You are? Good.

DR. NETON: It turned out, though, that hosp-- Hanford, for example, the local hospital did all the X-rays and they were pretty good about documenting all that kind of stuff. The hard part

is to figure out which one was required and which one was just part of their regular medical treatment because they were one and the same in many cases.

DR. ZIEMER: Where do you cover the information on incident reports in the profile, such as -- let's say the Y-12 criticality accident. Is --

DR. NETON: Okay, that would not really be included as a profile. We would include that as part of the personnel monitoring data. If a person were involved in an incident, or a group of persons, it would be covered that way. It's a good point, though, that that could be -- cover a large group of personnel that should be -- it should be evaluated, but right now we're not covering it in that site profile. I guess you have to determine at what point is it an incident on a couple of individuals and what's -- is it a site-wide incident.

DR. ZIEMER: Yeah, possibly if there were a release -- and I think even in the Y-12 there was some sort of local fallout -- I suppose the regular environmental --

DR. NETON: That would probably --

DR. ZIEMER: -- monitoring would capture that then, perhaps.

DR. NETON: Yeah, in the environmental. But we really were intending to treat the incident reports as personnel data, on a one on one basis.

DR. ZIEMER: Jim?

DR. MELIUS: Yeah, just to -- well, a separate question, but just to follow up on that, I would think it would be very important to try to capture those incidents in your site profiles 'cause again we have -- you know -- well, widows and children, people unfamiliar with what went on at the site, the survivors, and that may -- you know, they may not be able to tell you about the incidents or recall the incidents. And having them in a profile, you know, might help identify them. Now clearly if it's one involving a couple of individuals, that's different. But --

DR. NETON: Yeah, I'm not sure in my mind whether that would fit better in the site profile or in the occupational exposure matrix that we're developing so for a certain class of workers -- a chemical operator, 1952 at certain site, what their exposure characteristics were. And if it were a serious incident, that may be covered in there. We probably need to think about where that best fits.

DR. MELIUS: You're getting close to

answering my second question, also, which was how are you dealing with that -- how does that fit into this, I guess is --

DR. NETON: Yeah, that's a separate -- as a separate -- totally separate database which is really not part of this. I mean that is a worker profile database, to coin another term, I guess. You know, there's this occupational exposure matrix by job. You sort of drill down through a menu of site, year, job, building -- you know, if we could ever get that defined -- definitive, that sort of thing. It's a separate effort to this. Of course complementary. You know, they all kind of go together, but this is really to deal with non -- non-personnel monitoring data, those things that are generally unique for the site.

They would be -- the air sample database would be in here, of course, which would have the air samples over time, historic -- like say Fernald from 1952 to I think '89 or something like that, we got 60,000 air samples. Actually the Health-related Energy Research Branch has it. We haven't brought them into our database yet, but I know they're there. I've looked at them. So we have by building, by year, air samples to go over a 40 -- 30

to 40-year period.

DR. MELIUS: Back to this matrix, where do you stand with developing that thing?

DR. NETON: That's just getting started. I mean we have had discussions with ORAU -- second meeting we had -- talking about the structure of that database and how it would be populated and that sort of thing, but we haven't done -- we've done very little with that except scope out the parameters of it.

DR. MELIUS: And just one follow-up to that, and I think this fits more with that database, is a issue Ken Silver brought up, I believe, yesterday in public comments, but is the issue of other chemical and other toxic exposures at these sites. Are you attempting to obtain any of that information, both for this -- site profiles and for this matrix?

DR. NETON: At the current time we have no plans to capture chemical exposure data. It's not -- it wouldn't be desirable. It's not within our charter or within the scope of work with the contractor. And I'm not saying we couldn't do it, but right now we're not doing that at all.

DR. MELIUS: I question your statement it's not in your charter because I think there's some

issue about interaction with chemical exposures, that's something you're looking into, and I don't know where it fits on the priority scale and I -- clearly I don't think it's the top priority, but at the same time, if -- you know, this whole issue of records being lost with time, and this may be the time to capture some of that information. I'd hate to see you getting some of that information and throwing it out. I guess that's my --

DR. NETON: I understand what you're saying.

DR. MELIUS: -- my concern and, you know, again, at the same time it could be an overwhelming --

DR. NETON: Right.

DR. MELIUS: -- task and -- directing. But at some point I think, as part of this program, it has to come to grips with this issue of, you know, other exposures and how they interact with the -- for people with cancer, so --

DR. ZIEMER: It would certainly be nice if there's a convenient way to capture that information without impinging greatly on the main task because you're going to stumble across it, definitely. And even if there's a separate bin, you just throw it in there and preserve it. It's something to think

about.

I want to backtrack just briefly on the incident issue again. Some of the incidents -- perhaps the SL-1 is a good example, where they had a major sort of meltdown or -- well, everything. But there's a lot of clean-up activities associated with that, and if one were able to capture the time/location of that, there might -- it might show up as important if you could identify that some particular worker was around that site at that particular small window of time and might have been involved in a clean-up activity that might not otherwise show up. Again, it's not clear whether or not that would already be captured in the regular data.

DR. NETON: Yeah.

DR. ZIEMER: Let's see, Mark, I guess you're next or -- oh, Mike was next and then Mark.

MR. GIBSON: As far as the folks developing the site profile and the information you're requesting, do you have adequate folks with Q clearance that would have access to information that's still classified about isotopes and the processes that they were used in?

DR. NETON: Good point. That has not been

an issue so far, but we do have people with Q clearances on our staff. Within NIOSH we've just added one -- we're going to have three within the next week or so. But ORAU has come to the table with a large number of Q-cleared individuals, so we don't view that to be a problem.

MR. GIBSON: And just a kind of follow-up to Jim's comment, there are some processes that were developed in a -- I've got to be careful how I state this -- that there were isotopes attached to different types of material in the process of whatever they were doing that changes the effect of the dose, and it also may have a toxic effect inside the body, so it could have some relevance to -- the two combined could affect the dose and the (inaudible).

DR. NETON: I understand. I think we're aware of some of those issues at some of the sites that are out there. So far, outside of the quantity material for certain processes, we've not had a problem with the isotopes. I know that quantities tend to be restricted at a lot of facilities -- the release of that information. In fact, that's been an issue with some of the interviews. People are uncomfortable talking about quantity of materials.

MR. GIBSON: I guess what I'm saying, that some of the isotopes' half-life is altered in the dose to the body because of the material that's adhered to it does not exit the body the way it --

DR. NETON: Right. It sounds like you're talking about maybe like metal trichtides* and that sort of thing. Yeah, that's going to be a unique situation for us to evaluate and -- but we haven't had to cross that bridge yet. But we do expect a challenge in the dosimetry in that area. There are very few models -- at least the ICRP model (inaudible) cover that.

MR. GRIFFON: Yeah, the -- I just wanted to go -- this is a new term on me, too, this worker profile database, but it's --

DR. NETON: I just coined a new one.

MR. GRIFFON: -- it might be something we have to add to our -- in the review. The -- I guess what I was trying to understand was, for the worker profile database, it seems to me that this matrix would benefit from being tied into the site profile data. And do you see -- I mean I look back at slide number six of yours and it seems like you're first relying on co-worker data, and then if co-worker data isn't available, then you're deferring to site

profile data. Maybe that's too strongly stated.

DR. NETON: Well, that is sort of the hierarchy as it's outlined in the rule. I mean that is true. If we can establish that the co-worker data were valid and would be representative of that work environment.

MR. GRIFFON: So would this matrix -- do you see this matrix being primarily populated with co-worker dosimetric data as opposed to --

DR. NETON: Yes. Yeah, co-worker data as far as their monitoring results, TLD's, bioassay results, those sort of things 'cause that's our second layer. I mean once there is no individual monitoring data, we start looking for representative co-workers, and we would look at their bioassay records first. Now that's not always going to be the case 'cause we may not find a representative work population. But that would be our hierarchical approach.

MR. GRIFFON: We -- we've -- I think -- yeah, I think you're well aware of some issues about using co-worker data so I won't belabor that, but --

DR. NETON: Right.

MR. GRIFFON: -- the next question I had was on the matrix that you presented. I think it's your

eighth slide there, internal dosimetry data. For the various sites you showed the -- what you have received so far and -- sorry to get you to pull that up.

DR. NETON: That's okay.

MR. GRIFFON: Yeah, the question I had was on slide number six, which is titled area monitoring, process descriptions and source terms. Those -- those things I see as three of the key site profile fields, and yet they're not on this matrix. I just wondered if you -- if there's anything to update on that.

DR. NETON: Yeah, I think I touched on that is that we have very little of that information. The reason this is populated the way it is is because those were the big four that we started with as what we called the site profile. And then it made sense as we went on to include any non-worker-specific data into the site profile, which would be the area, TLD's, the air samples, those kind of things. So we have not really formally requested, on a global basis, those data from the Department of Energy. We were working with the Office of Worker Advocacy. We're doing things like going to Los Alamos today, but those are somewhat isolated tasks

that we're doing right now. We have not embarked on a massive effort to go out there and capture all those databases. But we're certainly hoping that, working with ORAU, we can move into that area within the next couple of months. Bill Tankersley is the person that's leading up that effort for the ORAU team.

So yeah, these are what I originally called site profile, and we felt that if we had -- if we had -- this is if we have worker data, if we had bioassay results and TLD results, this is the minimum we need to complete a dose reconstruction for someone whose PC was not greater than 50 percent, just adding up their -- the TLD records or something. We would need to look at the external dosimetry program to calculate missed dose for the monitoring program to add that into their record. We would look at the internal dose to calculate their missed dose for the internal exposure, add that back in. Look at the environmental dose, add that back in, and medical dose. Without those four, you can't complete a dose reconstruction, even with co-worker data.

Now if you have no co-worker data, then you move in -- or not co-worker data. Without actual

individual monitoring data. If you don't have individual monitoring records, then you've got to move into the co-worker data, and then the third tier would be those area results.

MR. GRIFFON: And I would -- I guess I would just -- I haven't seen this matrix or -- you know, I'm trying to understand how it might work, but I think there's a real opportunity or potentially a missed opportunity to integrate the site profiles with this worker matrix. I think you have to think that out 'cause you're going to have -- you're going to have building process data, potentially jobs and source term data, and if those don't agree with your other site profile -- or worker profile database, if there's large inconsistencies there, I think that might -- you know --

DR. NETON: That's a very good point.

MR. GRIFFON: -- be worthwhile to look into. Yeah.

DR. NETON: And I guess if -- I'd like to point out, they're not really separate databases. These are relational databases so they're not sitting on one computer and another. I mean they're all tied. But you make a very good point, that consistency -- a group check is consistency between

the actual worker monitoring data and what appeared to be there in the workplace 'cause that would give you a handle if the worker monitoring program was capable of detecting --

MR. GRIFFON: Exactly.

DR. NETON: -- what the air sampling program was saying. So it's sort of the old story, you don't use people as human air samplers. You go back and look at the air sample results and see if they're adequately protected. It may give you some handles on missed dose, as well. You could put an upper bracket on the missed dose based on the worst available air sample result. There's a lot of tie-ins here that you can't get into now or...

DR. ZIEMER: Additional questions? Comments?

(No responses)

DR. ZIEMER: There appear to be none. Thank you, Jim.

BOARD MEMBERS DEALING WITH THE PUBLIC

DR. ZIEMER: Next on our schedule is David Naimon, who is with the office of general counsel of the Department of Health and Human Services. We've asked David to speak to the Board in terms of what -- let me characterize it as what can you and can you

not say in terms of public pronouncements relative to your activities on this Board. So David, if you would give us your advice. David's that other attorney I was talking about yesterday. He's a real attorney. He's doing legal stuff. David, we do appreciate your being here today. Thank you.

MR. NAIMON: Thank you, Dr. Ziemer, and thank you for the invitation to be here to talk about Board members' interactions with the public. I understand some of you had some questions about this. What I'm going to try and do this morning is discuss with you some of the relevant laws and rules that govern us, then talk about some examples of situations that you may face and discuss possible responses and guidelines to follow; and then if we have time, answer general questions from Board members. If you have specific questions about your own individual circumstance, we probably should talk during a break or after the meeting, but I'd be glad to answer your general questions.

For starters, here's the definition of a Special Government Employee, which all of you are. A Special Government Employee is an officer or employee in the executive branch who was appointed to perform temporary duties, with or without

compensation, for a period not to exceed 140 days during any period of 365 consecutive days. That's relevant because of the statutes that govern what government employees do that do apply to Special Government Employees.

In this case 18 USC 205 bars a government employee, including a Special Government Employee, from acting as an agent or attorney for a specific party or parties before any government agency in any particular matter in which the U.S. is a party or has a direct and substantial interest.

The key thing here is that this applies whether the employee solicits or accepts compensation for such services or not.

So if you are representing -- if you are a Special Government Employee and you are representing somebody before the government, you run the risk of violating this criminal statute.

OGE is the Office of Government Ethics of the United States government. It has standards of ethical conduct that apply to all employees of the executive branch of government. This particular standard -- actually the handout that you have may have mis-cited it. The letter (b) may have been missing, although if you went to the rule itself,

you would see that this is really the only one where there's a number eight. But 5 C.F.R. 2635.101(b)(8), employees shall act impartially and not give preferential treatment to any private organization or individual.

Part of my advice for you all is not only that you want to avoid giving preferential treatment to any private organization or individual, you want to avoid the appearance of giving preferential treatment to any private organization or individual.

And then 5 C.F.R. 2635.702, an employee shall not use his public office for his own private gain or for the private gain of friends, relatives or persons with whom the employee is affiliated in a non-governmental capacity.

Again, the theory is pretty much the same, that you're not using your office, you know, to assist your family and friends.

I'm sure you all have heard about the Privacy Act many times, but I wouldn't be doing my job if I didn't remind you one more time that the Privacy Act essentially prohibits disclosure to any third party without the written consent of the individual to whom the record pertains unless a statutory exception applies.

The kind of materials we're talking about are -- include name, Social Security number, date of birth, medical history, the point here being be careful about getting into individual personal details when you're discussing things with members of the public. That actually includes talking to them about themself.

Under the Privacy Act people can sue for access to records or they can sue when they think that something has been disclosed about them and that harms them.

The penalties for improper disclosure, there's a civil penalty that can result in money damages. And if they substantially prevail they can get attorney's fees, which of course is an additional incentive to sue. And then there's a criminal penalty for willful violation by any agency employee, including a Special Government Employee, which is a misdemeanor, but it's punishable by a fine of not more than $5,000. So obviously violating the Privacy Act is something we don't want to get into.

And then there's a standard of conduct that is somewhat similar, also dealing with privacy issues, employee shall not allow the improper use of

non-public information to further his own private interests or that of another, whether through advice or recommendation or by knowing, unauthorized disclosure.

So here's an example of a situation you may face. Someone comes to you and says what is NIOSH's position or HHS's position on the Special Exposure Cohort? And you can see we have some possible responses here -- you believe everyone should be in the Special Exposure Cohort, you believe no one will be in -- should be in the Special Exposure Cohort. You can see that there is one response that is in yellow: I can't speak for the agency or the Board, but the Advisory Board sent a letter on this topic that OCAS would be glad to send you. Then the response in green: I'm sorry, I can't speak on behalf of the agency or Board; you should contact OCAS.

The theory behind the yellow answer and the green answer, either one is considered an appropriate answer. The yellow answer is yellow, meaning that you should have a little bit of caution if you're going to answer with more of the details here. If you start talking about what the Advisory Board said in a letter and you were to

mischaracterize it, you obviously raise a possibility of raising an issue that isn't already there.

The green answer, which is the -- I'm sorry, I can't speak; talk to OCAS -- is the safest answer. That's why it has the big green light. Obviously the safest answer is that you don't speak on behalf of the Board. The general guideline here is that members of the Board don't speak on behalf of the agency or the Department, and they also don't speak on behalf of the Board unless the majority of the Board has approved the position that you are taking. That is a guideline to -- certainly to follow, but obviously there are going to be times when people are going to expect that you're going to know things because you are a member of the Board. And so that is why if you -- if you do have occasion where they say to you tell me more about the Special Exposure Cohort process and you feel more comfortable giving more detail, the yellow light is there to tell you that you want to stick to what is in the public record, what anybody sitting here in the room would know, and that way no one can suggest that you're using your position to help a specific individual.

Another possible question, I heard you

reviewed a dose reconstruction similar to mine at the Board meeting that was paid; why didn't I get paid? And then of course possible responses: Your dose was too low. I'm sorry, but as a Board member I must stay impartial and so I can't discuss individual claims with anyone; OCAS will contact you to discuss your dose reconstruction report and what it means. Or OCAS couldn't do your dose reconstruction.

The guideline here is that when you start getting into the merits of individual claims, you're in kind of dangerous territory and that even if -- even if you watched the discussion yesterday on dose reconstructions and you think you know precisely who was being discussed -- obviously here there were no names mentioned or anything identifying here -- you're much better off avoiding discussing the individual claims and leaving that to the agency.

Maybe a general -- a comment that you get when someone finds out that you're on the Board and they say can you tell me what I have to do to qualify for compensation -- which obviously, as we all know, is a pretty complicated question. One possible answer, this is obviously -- this is the green light answer: Each case is different; you

should contact OCAS or the Department of Labor to discuss the merits of your claim.

This would be not only an unwise answer but a wrong answer: You need to have a minimum of 300 millirem of dose per year. You have to gather all your records and send them to OCAS; or the law says that you can get compensation if it is shown that is as likely as not that your cancer was caused by your work-related radiation exposure. Contact OCAS for more details.

The only reason that that particular answer has a yellow light on it is that you are now citing the standard that's in the law. If you cite it correctly, then it's really not a problem because all you're doing is telling them what's in the public record and that's, you know, relatively easy. If you cite it incorrectly or if you don't remember precisely the quotation, you do run the risk that somebody later is going to say that so and so member of the Board told me that the standard was X; now you're telling me the standard is Y. You've created a controversy for yourself that you're probably better off without. That's why -- again, the green light answer is to avoid it if -- you know, if you're confident you're citing things accurately,

but it's also an appropriate answer to -- you know, to discuss what is in the public record, what is in the law, as long as you're citing it correctly, the guideline being Board members may discuss public information. You also may refer all requests for information to the OCAS web site or to the office. Referring someone to the web site is always a safe answer because that's clearly, you know, available to anybody.

Question you could be asked: That last dose reconstruction was from location X. Do you think it was John Doe's? And of course -- yes, I'm sure; I remember him being in that job during that event. No, it was Jane Public's; I remember her describing that event to me at lunch the day after it happened.

The green light answer: I'm sorry, as a member of the Board I'm not allowed to discuss the identity of any claimant. If you start identifying claimants you run the risk of running afoul of the Privacy Act. To protect personal privacy you're better off not speculating on the identity of claimants from the dose reconstruction reviews.

This is a question I'm sure many of you have received: Why is OCAS taking so long to do my dose reconstruction? Possible answer: The Department of

Energy is taking too long to get OCAS records. The yellow light answer: NIOSH has recently hired a contractor to assist with dose reconstructions, which should greatly speed up the process. And the green light answer: I can't speak for the agency. You should contact OCAS to discuss your concern and get the most up-to-date information.

The theory here is again the same, is that your speculation about these kinds of issues, because you're Board members, is going to be treated differently than just anybody speculating about this. If you stick to the facts and direct questions to the agency, that is the safest answer. If you stick to things that are in the public record, such as the fact that a contractor was recently hired, that is certainly permissible. But again you get into -- you're getting into territory where you have to be very cautious because you begin to run the risk of using information by virtue of being on the Board. And remember that what you say, because you're on the Board, your speculation is going to be treated differently than just anybody's speculation.

Possible question you would receive: When will HHS issue the Special Exposure Cohort final

rule and when will the Board take action on my Special Exposure Cohort petition? Some possible responses: We expect the regulation to be issued in December and we will take up your petition in January. Your petition looks great; I'm sure there will be no problem once the rule takes effect and we will get your petition on the agenda. And the green light answer: I'm sorry, but it would be inappropriate for me as a Board member to try and predict future actions by the agency or the Board.

The guideline here is that if you predict a future action by this Board, you could give people the impression that the Board's deliberation was not what decided the issue; that it was decided somehow previously, prior to the full presentation of the petition, all the relevant data. That's a risk that you take by being a Board member and commenting on what the Board's going to do in the future. Sometimes views could change, and of course it could be premature and misleading to the public if you make comments before the decision is made.

The other problem of course with speculating on future actions is that it is in fact speculation and if you think you know precisely when your regulations will be issue or all that, I think it's

a very difficult thing to predict so again, your safest answer is to -- is to avoid predicting future actions.

DR. MELIUS: What if we quote Larry, who said -- whatever he said, I think in January, or something like that? What if we say we were told at the last meeting by -- he didn't tell us the year, but -- part of the public record and so forth, that's --

MR. NAIMON: Well, I suppose that Larry and I could have a separate discussion about whether the director should be speculating about future action, but if you comment on something that is said at a public meeting and you say this was said at the last Board meeting and you quote it accurately, then you have not -- you've not used your Board position -- you're in the same position as anybody who's read the transcript or sat in the audience here. So that obviously is not a problem, you know, to quote what actually was said. The danger you run into there is that if you quote what you think he said and it's not what he said, that again you raise the risk that somebody's going to read into your interpretation of what happened that you heard something outside the Board meeting that, you know, you were interpreting.

DR. MELIUS: Larry guaranteed that they'd be issued by January.

MR. NAIMON: Now that I would -- I would have no doubt knowing that that would not be true.

So -- okay. And another possible question: Can you help me file my claim form; question six is confusing to me. And I know this one would be particularly difficult for any of us because you're in a situation when you really want to help somebody and they're having problems, and our natural human reaction may be sure, let me have it and I'll bring it in tomorrow with the answers filled in; or let's have lunch and discuss this.

Actually the -- again, the safest answer: I'm sorry, but as a Board member I must remain impartial and so I can't assist you with your individual claim. You should contact DOL, DOE or OCAS for assistance.

Your role is really not assisting claimants with filing their individual claims. You're directing them to the proper place to get assistance. You are in a very good position to be able to tell them all the different places where they can get assistance. If Board members are assisting individual claimants, you run the risk of

a perception that they have special favors. The claimant may feel like they're getting something more than just a knowledgeable person's assistance. And obviously someone else looking at that could get the wrong idea, as well. So it's really not appropriate for Board members to be filing -- you know, helping individuals filing claims.

A question that you could get, especially if you yourself have previously worked in one of these locations: Can you tell DOL that my deceased spouse worked at location B from 1955 to 1967; you were there; I don't have any records. The yellow light answer: Yes, I may sign an affidavit to that effect as a fact witness. The green light answer: I'm sorry, but as a member of the Board I shouldn't get involved in individual claims. It would be better if you could get someone else to do this. The third answer: I'm on the Board. I'll be happy to call DOL and tell them.

The guideline here is that you can be a fact witness about things that you have personal knowledge about. To avoid the appearance of preferential treatment, you should not use your Board affiliation in providing the factual information. The safest thing is to have other

people provide factual information if there are other people who are available because then you don't have any hint of the idea that there's something special going on because you are a Board member. That's why there's the -- it's -- the yellow light answer is that you can sign the affidavit to that effect as a fact witness, the caution being that you want to avoid using your affiliation as part of that and that you want to stick to the facts, but -- and if there's someone else available to do that that you obviously avoid any potential perception that there's anything wrong going on, although obviously if you just stick to the facts, there's -- you know, you are a fact witness, like everyone else has fact witnesses, it would obviously be a disservice in some situations for you not to provide that information if you actually have personal knowledge.

So to summarize, Board members should not specifically assist anyone with their claim except as a fact witness; should not be using Board position -- your Board position to advance any claim or share any confidential information. Board members should explain that any information that you are sharing is publicly available, is not official

but from your own memory and may be incomplete, and more complete official information is available from OCAS. So again, if you do end up providing your own information, you want to make it very clear what you're doing for people, that you're not providing them with the inside track. You are providing them with otherwise publicly-available information. It just happens that you know it because of your -- because you're here and that it's from your own memory and that it's not an official position. And again, the safest thing is to refer people to other publicly-available places.

Now if you get inquiries from the media or from Congress, essentially the same guidelines apply. The difference is is that you have additional resources for help in those circumstances. And if you prefer, you can refer media inquiries to Fred Blosser from NIOSH and Congressional inquiries to Larry. If you do choose to speak, again, you want to make it clear that you're speaking as an individual, not for the agency or for the Board. You want to limit yourself to public information and say that that's what you're doing. And you want to -- you have the opportunity to consult with Fred for medial inquiries and with

Larry for Congressional inquiries to coordinate your response with the agency so that the proper information is being provided.

Just in case you need it, there's Fred's contact information. It also should be in your notebooks. You can reach him at 202/260-8519. I know he would be happy to help you with those inquiries, and I'm sure you all probably have committed to memory the phone number and e-mail and all that for OCAS. And then I've also provided you with information about the Department of Labor and Department of Energy numbers where you can refer people if you are so inclined.

And that's all I have. Thank you very much. I appreciated being invited to do this.

DR. ZIEMER: Thank you very much. We're going to allow some questions. This will be questions from Board members only. Let me begin. I want to pose a scenario which -- I'll make it very specific. Let's say Wanda Munn is contacted by a reporter from the Tri-state Herald and the reporter says I've learned that you've been appointed to this Board. Tell me why you were -- how you were appointed, what does this Board do -- information. What is it that this Board does? I don't think the

Tri-state Herald will be happy if she says I can't respond; call Larry Elliott. So what kind of things can she say? What would you say, Wanda?

MS. MUNN: I'd like to comment on that. I try never to dodge a question if I can avoid it, and I think the suggestions that we've been given are apt. Most of us here who've dealt with the public and who've dealt with the media are well aware of the fact that one must be cautious in how you couch what you say because it's not going to be reported accurately anyway. You know, they can't put all your words in there and they're not going to add all your caveats. So I -- what I would tell them was that I was appointed to this Board by the White House. The internal workings of how those appointments occur are unknown to me -- because that's true; I have no idea -- that I know that there were both geographic and professional qualifications involved and I submitted the application form that I was requested to and was appointed to the Board. It's my understanding that the purpose of this Board is to see that the existing law is being approached in an appropriate manner by the governmental agencies that are involved and that it is a very complex process; that

we're meeting on a fairly regular basis to do that. And if they asked other specific questions, I'd attempt to answer in that same vein. I just think you have to be reasonable, but you do -- and it's my opinion that you have to answer questions. Just simply referring people --

DR. ZIEMER: And your response would give somewhat generic answers, maybe not necessarily quoting verbatim from the law but --

MS. MUNN: No.

DR. ZIEMER: This get to the point I'm getting at because I get these same kinds of questions, and even if you quote verbatim from the law, the news people fiddle with it.

MS. MUNN: Yeah, it's not going to be put that way.

DR. ZIEMER: So could you give us a little help on -- sort of scope out -- you know, how do you approach -- I don't think it's a problem typically if somebody -- you know, I used to work at Oak Ridge. If somebody from Oak Ridge came to me and says help me fill out my form, I know I'm not going to do that. I'm more concerned about news reporters. Help us with that.

MR. NAIMON: Okay. Well, first I would say

that I'd have to -- Ms. Munn's answer was great. The one thing that I would add is that both Larry and Fred are available to assist in terms of -- if you're going to get a question that says what are the duties of the Board, and you want to answer in more of the specifics rather than just in general, then obviously the agency is available to provide you with information that you can use to answer that question, as well as they can answer the question themselves. If you prefer to be the one that tells your local paper what it is that this Board that you've been appointed to is all about and -- but you're not completely comfortable with the idea that you can, off the top of your head, rattle off precisely what the duties of the Board are -- and you don't want to be quoted in the paper saying that the Board's going to do something that in fact the Board's not going to do -- then obviously you have those resources available. And Fred is going to be much more qualified than I to answer the question of precisely how to deal with reporters to make sure they get it straight. My suggestion on that would be that if you had, in writing, the charge of the Board that you offer to that reporter the facts in that charge. It's a lot harder for them to misquote

your description of what the Board does when they have it in writing in front of them than it is if they're just taking notes from what you say and they're not being as precise as you're being. But obviously NIOSH has staff that, you know, really is designed to help you in dealing with those kinds of questions so that -- so that you obviously are -- are giving accurate information and don't get into a situation where you're giving information that somehow comes back on you in some way, and also that -- to help you with kind of the fine points of dealing with -- with media questions.

MR. ELLIOTT: I'd like to expand upon this a little bit. I hope it's apparent that we're not prohibiting Board members from talking to the press or Congressional inquiries. And I want you to understand also that Fred and I can help you in this regard, too. The type of assistance that Fred can give you is -- we think we have an obligation and a responsibility to help the media get it right. It is a complex program. And when we see newsprint articles that mix and confuse the technical aspects of this program -- subtitle D, the state workers comp program, with this program on -- the Federal program under part B -- we have to call the reporter

-- Fred and I call the reporter and we have to go through a long diatribe of what -- how did they get the information incorrect and how can we get them back on track. We want to avoid confusion in the public by these inaccurate press releases. So Fred can assist you by contacting the reporter before you actually talk to the reporter and finding out what it is he or she wants to know, what the questions are that are going to be asked. We can help put those questions in front of you. Fred can work with you in developing your responses, if that's what you'd like.

There's also an aspect here of follow-up. You know, the reporter may want to come back at a later time and touch base with you again, and that's certainly appropriate and it's something that we can help with, as well. So you know, this matter of assistance -- don't take it lightly. We take it very seriously that we want to get the right information out to the public. We want to help folks understand this very complex, technical program, and this is one of the ways we think we can do it. So I just offer that to you, that -- for your consideration to seek us out for assistance.

DR. ROESSLER: I certainly avoid the press

whenever I can, and I think I'd take this approach because that's my attitude there. But the one thing I could picture happening to me, and perhaps others on the Board, is that we'd be asked to go to maybe a local Rotary meeting, or for me, maybe a local health physics chapter meeting, where people are very interested in this and sincerely interested and they want to know more about -- maybe in particular the science. I would assume on that that if I were to prepare a talk that I could do it from materials on the web site, which are publicly available, and also use the notebooks, the handouts like yours and everyone else's, the written part, because that is publicly available. I hope I'm correct on that.

MR. NAIMON: You are correct that everything you've described is publicly available and could be used for that purpose. The thing you have to be concerned about, which I'm sure you know, is you go into that situation and they start asking you specific questions, maybe even about specific claims, and then you're left with having to -- you know, having to defer those -- and obviously it's easier for some people than others to deal with that situation.

DR. ROESSLER: And I think what you put on

the slides there, the wording, is very helpful in that regard.

MR. NAIMON: Thank you.

DR. ZIEMER: Do we have other questions from Board members?

(No responses)

DR. ZIEMER: Everybody had their questions answered then, it seems. Okay, thank you very much for --

MR. NAIMON: Thank you very much.

DR. ZIEMER: -- helping us in this area. We are a little ahead of schedule and that is, in a sense, good because I'm somewhat hopeful that we can accelerate a little bit today's schedule because there are some here that have to leave before the day is over. I think -- Henry, I know you have to leave shortly after noon, in fact, and we're not going to be done by then. But we will try to get as much as we can done and maybe be able to finish at least a little before 5:00. In any event, we'll stick with the agenda and -- just a little sooner. We'll take our break and then we'll continue with the IREP updates immediately after that. So we have a 15-minute break.

(Whereupon, a recess was taken.)

IREP UPDATES

DR. ZIEMER: I think we're ready to reconvene. The next item on our agenda is an update on IREP and the cancer latency models, and Russ Henshaw's with us today and Russ is going to lead us through that discussion. Russ?

MR. HENSHAW: Right here. Can you hear me?

DR. ZIEMER: Is that on, Russ? Get it up higher, too.

(Pause)

MR. HENSHAW: Well, good morning. I'm Russ Henshaw. I'm the staff epidemiologist with NIOSH Office of Compensation Analysis and Support. I -- by the way, I want to welcome the two new Board members. Speaking as someone who was a union organizer in a former life, it's a really distinct pleasure to see the two new members, and I know I speak on behalf of our entire program at NIOSH that greater diversity in background can do nothing but enrich the program, so welcome aboard.

It's my pleasure this morning to talk about an evolving issue regarding cancer latency, and in particular the latency exceptions for leukemia and for thyroid cancer. If you would consider this as more or less a status report, this is an ongoing

issue. As you'll see as we get into this, there are a number of options to take. NIOSH has not made a decision on this. This is informational to apprise the Board of what's going on.

I do want to mention, by the way, that I'll sometimes be using the term Time Since Exposure, abbreviated frequently in the slides as TSE, as -- synonymously with the term latency. And for our purposes, we're defining latency as the interval between exposure and diagnosis.

Also the material I guess is maybe moderately complex, so I'd be very happy, Dr. Ziemer, to take questions at any point during the presentation.

Well, as you probably know, a traditional assumption in cancer risk modeling has been there's a minimum latency period required for leukemia of two years. You've probably seen that in the literature. And similarly, three to five years for thyroid cancer. NIOSH-IREP is based on the NCI-IREP, the National Cancer Institute's version of IREP, which in turn was developed from the radioepidemiologic tables. So NIOSH-IREP incorporated that same assumption, that it is biologically implausible, if not impossible --

although that's controversial and I'll get into that a little later -- that a two-year period is necessary for induction of leukemia after exposure and at least three years for thyroid.

That's not the case, however, for all other cancer models in IREP, both NCI and the NIOSH versions. In all other cancer models, some risk is factored in at all times since exposure.

To give you a little bit of background -- and again, this is an ongoing issue. It's really kind of late-breaking. Some of the information I have that was too late to include in the slides, I just received Friday afternoon, and I'll talk more about that as we get into this. But this issue sort of came up, although we thought about it off and on, but this reconsideration of the latency periods was really prompted by the dose reconstruction on a claim. Not a hypothetical claim, but a real claim. A worker who actually died from leukemia after a series of multiple exposures, culminating in several exposures within two years of his diagnosis and actually early death.

In doing the dose reconstruction, the health physicist who was working on this, Tim Taulbee -- you may have remembered from previous Board meetings

-- was concerned that none of the exposures within two -- none of the exposures within two years of diagnosis affected probability of causation. And Tim wasn't really aware at the time that that was because IREP ran zero risk for those exposures.

That actually led to the series of internal discussions within NIOSH. And if you think about it, does it make any sense, for example, that an exposure two years and one day prior to diagnosis counts toward probability of causation, but an exposure maybe one year -- one day less than two years counts zero. The consensus at NIOSH was that that's probably not appropriate. We wanted to rethink the whole issue.

After a series of internal discussions and e-mail exchanges, we then contacted SENES. SENES is our -- the agency that actually created IREP. It's under -- (inaudible). It's under a contract to both NIOSH and NCI. We asked SENES to develop some new alternative latency models for thyroid cancer and for leukemia, factor in at least some plausible risk of exposure under two years for leukemia and under three years for thyroid cancer.

SENES did that -- in collaboration actually with Dr. Charles Land at NCI, developed new

alternative adjustments for short latency, which NCI reportedly is going to incorporate it into their -- incorporate into their IREP. I don't think that's been done yet, but it's on the verge of being added to their program, the -- being added to their software. The programming has been completed, it just has not been installed, I believe, on NCI-IREP, and the decision is still pending at NIOSH.

Charles Land, by the way, is in Japan right now. He's been there for a couple of weeks and I think is expected to be there for two or three more weeks, so he's not immediately available for consultation on this. But reportedly NCI is going to adopt these new models.

Just a little -- just to flesh this out a little bit, that claim that actually led to our reconsideration of these latency assumptions involved an electrician who again had a series of exposures within two years of diagnosis of leukemia. His last exposure he had a potentially high dose. He spent eight hours working on an electric motor. He wore no protective equipment, had no monitor, was not advised in any way by the employer, reportedly, that there was a radiation risk. The next day he came back to work and found the area roped off as a

radiation hazard.

By the way, this claim is not being held up by this issue. This particular case we're still awaiting records from DOE.

But in any event, that exposure has, according to Tim -- I'm not a health physicist, but according to Tim, has a potential dose of anywhere from eight or ten rem up to more than 100 rem. Tim thinks it's more likely going to be closer to the ten rem, but again under our current model, it's not counted at all and we think it probably should be.

Well, the new latency adjustments developed by SENES -- again, in collaboration with Dr. Charles Land of NCI -- would do a couple of things. They factor in the risk below two years for leukemia and below three years for thyroid cancer. They employ an S-shaped latency correction factor, add short latency periods, and they also factor in uncertainty around the mid-points of the S-shaped curves. Our current models for leukemia and thyroid, again, cut off at two years, but the latency points are fixed. It's not an uncertainty distribution that is included in the IREP calculations. The new models do factor in uncertainty around the mid-points. They actually -- during a Monte Carlo sampling, the

mid-points vary by I think it's 33 percent for leukemia and I believe 40 percent for thyroid.

So what is the status of the revisions? Again, programming is ready to go, reportedly about ready to be incorporated by NCI, still under consideration by NIOSH.

This is a graph of the so-called S-shaped latency adjustment, and it's -- as you can see here, this is the current model, the proposed model is in blue, and hence the S shape. And I think the key points which should be readily apparent by this graph -- or at least a couple of things. One is that the proposed model results in a lower reduction at four years time since exposure, but -- actually kind of surprisingly, at least to me, is it actually results in a greater reduction at two years time since exposure. The consensus -- and again, this is -- we're still talking about this. You know, we've been very busy there and concerned primarily with the new dose reconstruction contract, so we haven't been able to just take time out and really just pore through all this yet. But I think it would be fair to say that our consensus or our -- we're leaning towards, at least, at this point some discomfort with making a change that would result in any

lowering of probability of causation at any time since exposure. Nonetheless, that is reportedly what NCI is going to adopt for their IREP.

Just -- the graph, by the way, I don't -- this is time since exposure, and I have it out to seven years because that's where the two lines converge. They also converge at the mid-point, three years for leukemia. The vertical axis is the correction factor for short latency, labeled here the reduction factor because that's what it does.

Just a note about the epidemiological evidence here for the short latency assumption. It's really not very good. It's somewhat ambiguous. It's based on the settings of the Japanese cohort, the life-span study. And there is in fact no hard evidence, quite frankly, for the shape of this proposed curve. That curve was decided upon by Dr. Charles Land and by the people at SENES -- Owen Hoffman and Iulian -- I can never pronounce his last name, Apostoeai or something like that. But it's basically developed based on their expert judgment. Really about -- maybe the only consensus regarding the epi evidence is that latency does diminish as time since exposure approaches zero. I don't think anybody would argue -- to take a really ridiculous

case, but if somebody was cancer-free one day, exposed the next day and diagnosed with leukemia the third day, I doubt many people would argue seriously that that leukemia was caused by that exposure. But the question is, what is a valid, plausible cutoff point? Is it three months, six months, one year, one year and a half? No one really knows.

DR. ZIEMER: Just a -- a question here. You asked that we ask as we go, so here's one.

MR. GRIFFON: Yeah, if that's okay, yeah, just to clear something up in my mind, I thought the current model, as you described it -- and I haven't looked at a lot of leukemia models, but I thought it would have been a -- gone straight up at two and flat across with no reduction factor after two years. Isn't that --

MR. HENSHAW: Right, that's according to --

MR. GRIFFON: Am I reading this wrong or --

MR. HENSHAW: No, you're exactly correct, and let me just point out that -- pay -- pay more attention to the data points at the year intervals than the actual curve itself. There is no graduated reduction between years.

DR. ZIEMER: So you shouldn't really connect the dots, I think is what you're really saying.

MR. HENSHAW: Yeah, you know, I thought about that. I mean it could have looked a line off at this point, but you know, it's actually --

DR. ZIEMER: Is it a step function at two years, really? I mean --

UNIDENTIFIED: (Inaudible)

MR. HENSHAW: I'm sorry?

DR. ZIEMER: Yeah, it comes straight to two and then up. Right?

MR. GRIFFON: Yeah.

MR. HENSHAW: The current model?

DR. ZIEMER: Yes.

MR. HENSHAW: Right. There is no probability -- there's no risk factored in below this two-year point --

MR. GRIFFON: Okay.

MR. HENSHAW: -- for the current model.

DR. ZIEMER: It should be zero straight across to two, and then up.

MR. HENSHAW: Yeah, it's a -- kind of is a judgment call. It's somewhat --

MR. GRIFFON: The best -- if I come up from two to five, is there a slope -- I'm forgetting --

DR. NETON: I'd like to clear this up. There is no function associated with this graph.

It's best represented by a histogram. The lines are there just to show the general trends, but really you should think of those dots as histogram functions -- as a step function.

MR. ELLIOTT: There is no risk coefficients in the years zero to one and one to two.

MR. GRIFFON: I under-- but for example, on year three, the reduction factor is not one in the current model. There are differences between year two, three and four --

MR. ELLIOTT: Yes.

MR. GRIFFON: -- and so it's at five when you get a reduction factor of one.

MR. ELLIOTT: If you look at the risk coefficients between year -- starting at two, two/three, you see this -- a graduation in risk coefficient.

The other thing to point out here, though, is -- you know the -- what Russ was alluding to earlier on the proposed reduction versus the current reduction factor between years three through five, you lose probability of causation if you go with this. Risk coefficients decrease and your probability of causation then is decreased in the newer model.

MR. HENSHAW: Just to clarify this a little further, bear in mind that IREP accepts data only at yearly intervals. You know, it wouldn't be entered as like 3.5 years or something, and so the curve is just there to show the trend, as Jim said. That's a good point.

DR. ZIEMER: And Russ, in the proposed model there are actually values now between zero and one, or do you just --

MR. HENSHAW: Yes.

DR. ZIEMER: -- there's a value at one.

MR. HENSHAW: And at zero.

DR. ZIEMER: And at zero.

MR. HENSHAW: Yes, sir.

DR. ZIEMER: Just above the -- though very low, but nonetheless, not zero.

MR. HENSHAW: Correct. This is a similar graph for the proposed thyroid cancer latency adjustment, and you can see the same kind of trend here. The mid-point for thyroid is at five years and the lines converge at eight years, which is why I brought it out to eight years time since exposure. But you see the same kind of trend where the reduction factor is more claimant-friendly at six years time since exposure, less so at four years and

three years. Again, you know, it's a source of discomfort for us at NIOSH.

Any questions on this graph?

DR. ZIEMER: There are uncertainty bars associated with this new distribution, too?

MR. HENSHAW: Yes, sir. The uncertainty is at the five-year point and it -- during the Monte Carlo sampling, a lot -- the curve actually shifts at the mid-point by plus or minus 40 percent.

Question?

DR. ANDERSON: Yeah, my question was, for latency are they using the time to clinical recognition? I mean how --

MR. HENSHAW: Well, yes, diagnosis, correct.

DR. ANDERSON: Because, again, your other example, a number of these diseases are probably present --

MR. HENSHAW: That's right.

DR. ANDERSON: -- at least a number of months before, so if you wanted to pick a contributing, you could look at what's known about the progression of the disease and -- for instance, thyroid could have been there for quite a while, where leukemia is a little more aggressive.

MR. HENSHAW: You're exactly correct.

There's no opportunity in IREP to consider things like tumor, you know, doubling time and things like that. It's just the actual record of the date of diagnosis on the claimant's record.

DR. ANDERSON: But in your calculations here, they're also --

MR. HENSHAW: Yes.

DR. ANDERSON: -- using the same characteristics in the --

MR. HENSHAW: That's right.

DR. ANDERSON: -- data they're using.

MR. HENSHAW: Yes, sir, that's exactly --

DR. ANDERSON: So if the surveillance and diagnosis was earlier in one than the other then it could be (inaudible).

MR. HENSHAW: Well, if we're getting into the biologic -- biological plausibility of the period between presence of disease and diagnosis, right, that would -- we don't -- it's not a factor in any of the IREP --

DR. ANDERSON: Right.

MR. HENSHAW: -- inputs.

DR. ZIEMER: I think Gen Roessler has a question.

DR. ROESSLER: Russ, you're talking about

leukemia -- or had been on the previous slide -- in a very general manner, but in the second slide you talked about the four kinds of leukemia. What about chronic lymphocytic leukemia, how does that fit in here? What is the probability of causation?

MR. HENSHAW: Well, the assumption in the rule is that it's zero. I think it's the only --

DR. ROESSLER: So it wouldn't change.

MR. HENSHAW: Right. The only -- it's the only cancer excluded from compensation in the rule itself.

This is a rather busy slide. Without belaboring it too much, it's -- this is a hypothetical example of the probability of causation results comparing the current model to the proposed model. And the inputs are fixed -- male, born in 1930, diagnosed in 1980, exposed to 50 rem. Look at the table, the left-hand column is the year of exposure, this is the corresponding time since exposure. The current model results -- and that's the one that determines compensation, the 99th percentile, and the proposed model.

What I have here -- the figures in red are the higher values of the two models, and you can see that at two years the current model actually results

in a higher probability of causation than the proposed model. Not so at three and four years. The current model in this table is slightly higher at years five through 30, but there's a caveat there. As I mentioned when I started, this is late-breaking news. The data -- these runs were done by SENES at our request, and we found out Thursday of last week, after looking at these results, that they had used an old IREP code. We asked them to run it again using the correct code, and I also asked them to up the sample size to 2,000, which is the Monte Carlo sampling size used by the Department of Labor in determining the claim. The sample size on the web, however, is 1,000.

I just digress for a minute. We've also been talking about that. Just by way of brief background, when IREP was on the web for public comment and trial, we set it up with a default sample size of 1,000, for reasons of processing time. Since then, and now that claims are actually being worked on -- but since then, SENES has been able to greatly enhance the processing speed. We think there's no longer a need to leave that default sample size at 1,000, so we're going to direct SENES to raise the default sample to 2,000. Our concern

is that just due to the uncertainty factors, there are slight differences in results, depending on whether you use a sample size of 1,000 or 2,000. The 2,000 affords greater precision. As we're doing these dose reconstructions and sending claimants their data, we'd like to avoid situations where the claimant has a printout of results, gets on the web, plugs in the data himself and comes out with something else.

I also want to mention, by the way, that using the correct IREP code and upping the sample size to 2,000 removes this little anomaly here where -- with the current model showing higher probability at the longer latency periods. Using the correct code and a 2,000 sample size, it's actually very slightly higher at all points using the proposed model, although less than a percent.

I regret that you really need to disregard the exact date on the table, but again, this is very late-breaking and we didn't have time to correct the slide for the Board's presentation.

This -- also using the correct code and simulation size of 2,000 -- sample size of 2,000, this discrepancy is cut from four percent to two percent. It's still higher using the current model,

but only two percent higher than the proposed model.

Any questions on that? Okay.

This is another chart, but this one is showing probability of causation on the vertical axis instead of the latency correction factor, and this was using the data on the table you just saw, so again, it would be just slightly different using the correct code and simulation size of 2,000, but the point here -- the key point is to show that the probability of causation using the current model, which is in red -- or possibly orange, I'm not sure; I'm nearly color-blind -- but is slightly higher at two years since exposure using the current model, but slightly -- but the proposed model is slightly higher at three years and four years. And again, the IREP inputs are whole years since exposure, so there's no -- there's really no graduated risk between zero and one or one and two. The line is just to show trend.

Any questions? Okay.

So what are our options? Where does that leave us? Well, as I said at the beginning, we have not made a decision, quite literally. We really had insufficient time to even fully discuss it. But one option obviously is to simply echo what NCI is

reportedly going to do and incorporate the new S-shaped curve developed by SENES and NCI in collaboration. A second option would be to make an adjustment, but not necessarily use that NCI curve. As I mentioned earlier, we're not comfortable with an adjustment that results in a lower probability of causation, so we might, for example, direct SENES to develop a new curve that results in no decreased probability of causation at any time since exposure, but still factors in some risk below two years for leukemia and three years for thyroid. And a third option -- it's up here because it is an option -- is to do nothing. But I can tell you that, you know, I'm quite sure it's the feeling of everyone at NIOSH that that's not an option to be seriously considered. I think we feel strongly we need to make some adjustment. The question is what adjustment to make and how much -- if we change the model from the NCI proposed model, how to change it.

So again, you know, this is evolving. We just wanted to apprise you of what's going on. Not advise you, because that's your job, but to apprise you of what's happening. And I'm sure we'll pick this up again when we get back to the office, hopefully next week, but in the meantime, any

questions or comments on the issue?

DR. ZIEMER: I think Wanda has a question.

MR. HENSHAW: Yes, ma'am?

MS. MUNN: It's not really a question. I think it's a comment. It's very interesting and I think anyone who looks at risk is a little skeptical of step functions. But by the same token, Russ, you expressed some concern over the accuracy of the proposal that NCI's making based on the scarcity of data. I guess my question would be, looking at option two, how could you possibly convince yourself that your estimates would be any better than NCI's if you made a revision to that?

MR. HENSHAW: Well, that's a good question, and we do on rely on NCI as our cancer experts for this program. We wouldn't pretend to think that we have more expertise in issues like cancer latency than NCI. If we decided to deviate from what I think could fairly now be called the NCI proposal, reportedly, it would be a policy judgment, not a -- not a science-based judgment. Just really to err on the side of the claimant. But you're right, I don't have any delusion of thinking that we could come up with a model that's more scientifically accurate. It's really just a judgment call.

MS. MUNN: And anything that I would say would be just a judgment call, as well. One question with respect to the claim that started all this deliberation. Did I mis-hear you? Did I not understand that this claimant had had some exposure prior to the two year latency period --

MR. HENSHAW: That's correct.

MS. MUNN: -- that it was just these unanticipated, uncertain chronic doses occurred within the two-year period.

MR. HENSHAW: That's correct. And that's actually what really just by coincidence kind of makes this claim a good one to use to start reconsidering this issue because from what I've been told by the health physicist working on the claim, this person's cumulative exposures up -- post-two-year latency would result in a probability of causation of about 35 percent, based on the data that the health physicist has now. There is the possibility that changing this model will tip that claim from a status of non-compensability to one of compensable. But we won't know that until we get the records back from DOE and do some further work on it, but -- and that's -- actually that's a good point you raise because most exposure histories are

a series of exposures. So you take like that table that I showed earlier in and of itself, that was one acute exposure. But usually we're looking at whether or not to include some additional exposures in the cumulative total. That's where the latency -- the minimum latency assumption really comes into play, I think.

MS. MUNN: And that's really quite different than just starting at zero and assuming a step function at two years. That's really quite different.

MR. HENSHAW: I'm sorry?

MS. MUNN: This particular case is really quite different than one where you start at zero --

MR. HENSHAW: Yes.

MS. MUNN: -- and jump at two years. That's an entirely different thing.

MR. HENSHAW: Correct.

MS. MUNN: Given that additional uncertainty with respect to the impact that acute doses would have on an already-affected organism, although it makes a very interesting case history, my personal feeling would be that it would be unwise to base major changes in policy on that type of incident, since that individual does not really represent any

significant portion of --

MR. HENSHAW: Well, I think you're --

MS. MUNN: -- workers.

MR. HENSHAW: -- absolutely right.

MS. MUNN: Yeah.

MR. HENSHAW: Again, the point was just the issue that raised a flag and led us to start reconsidering the whole issue.

MS. MUNN: And I guess -- again, this is personal observation. Were I in the position of having to choose one of those three, which I am not, I would -- I think I would move toward option two, simply because it infers that some change needs to be made. You may not agree with the change that is being proposed by NCI, but at least it recognizes the need for some additional thought.

MR. HENSHAW: I should, by the way, mention that we have nothing in writing yet from NCI on their adoption of the new latency adjustment. This is all, frankly, reported to us through SENES. We expect that Dr. Land will notify us with the details and their justification for adopting the model, but we have nothing in writing at this point.

DR. ZIEMER: Larry has a comment here.

MR. ELLIOTT: And for the Board's further

information, to expand upon Russ's last comment, I believe the middle of last week we learned the current status of the NCI-IREP and the technical documentation -- this is what we were -- we presented to you -- we got Charles Land on the phone in Denver, if you recall, to talk about that. That document which stands as the foundation of the technical information that supports the NCI-IREP has been reviewed by the VA and those VA comments were sent back to HHS last week. And so I'm sure that had there been -- you know, they're wending their way down through the channels back to NCI, back to Charles Land, and when he arrives back from his sojourn in Japan he'll have those facing him. And that's why we haven't seen a letter yet, because they'll still have to take into consideration those comments, as well as what they're going to do with this particular issue. And in the Department, the Department will have to decide what -- they'll get a recommendation on how to handle this from NCI, and they may even have to go back then to the VA and make sure that the VA understands what's going on with this and accepts it before we see a final decision from HHS on this.

MR. HENSHAW: I might also mention, by the

way, really there are two separate issues here. One is the leukemia latency and the other is the thyroid latency. The evidence is a little better for thyroid that our -- the IREP model in both NCI and NIOSH is based on pulled data from not only the Japanese cohort but also a series of studies on medical exposures. I don't know -- I don't think we've reached the point yet where we're necessarily saying that the same course of action should be taken for both of these proposed adjustments. We really have barely gotten into looking at the thyroid issue yet, quite frankly.

DR. ZIEMER: This whole situation might raise the issue of exactly what this Board's role is in such a situation. That is, what is the threshold at which we participate in the decision? You know, that we agree that changes in IREP that are computer changes to make the program more user-friendly and so on, they don't have to check that out with us. We also have sort of agreed that NCI's model is what we kind of agree to. But there also is a statement, and I'd have to go back and look at exactly how it was worded in the rule, that suggests that significant changes in the IREP model have to be brought to the Board, at least for input.

Now we don't actually have before us a formal proposal because this is more of a status report. But at some point we will have the final sort of recommendation from NCI that will come to NIOSH. And then there will, I think, possibly be the question of to what extent, Wanda, you will actually have input on this. You made the statement that if I were to chose, but I don't have any choice. But in fact I -- this could be -- and the Board could easily say no, this is something you just let the staff handle it or you could say no, we want input on this issue. You have that opportunity right now of course, and perhaps at the point where we have kind of what NCI thinks their final recommendation is -- technically speaking, aside from --

UNIDENTIFIED: (Inaudible)

DR. ZIEMER: Or two, sure.

UNIDENTIFIED: (Inaudible)

DR. ZIEMER: Yeah, and yours would have theirs, with maybe a policy thing imposed upon it or something, so it seems to me that might be the next step, that the Board would be asked to react to a formal recommendation. Is that possibly the case?

MR. ELLIOTT: Yes, it -- that's very much

the case, as I see it. We certainly welcome your thoughts and your input at this point in time, and whatever advice you have for us to -- for our consideration in our deliberations about how we're going to approach this. I anticipate maybe at the next meeting we'll be coming back to you with not only what the NCI final version looks like and how they've handled it, but probably also what we would like to see done with it and what our recommendation would be. So there's certainly opportunity here for input from the Board at this point in time and in the future.

MR. HENSHAW: Might I just add, by the way, on that issue of NCI-IREP versus NIOSH-IREP, we do currently deviate from the NCI-IREP in a couple of cancers, skin and male breast cancer. And I'm told that -- you know, from talking with him -- there's no reason to believe that Charles Land has any problem with any of that. I mean he under-- you know, these are policy decisions.

DR. ZIEMER: I think we have Henry next and then Roy.

DR. MELIUS: And I've got some --

DR. ZIEMER: And Jim.

DR. ANDERSON: Yeah, I would almost back up

a bit that the issue of latency is, as you say, time since exposure and it's typically time since first exposure. So the latency here -- and I believe the data that they have is if your only exposure is within two years, what's your risk of developing disease, as opposed to what you're trying to do here is does more recent -- how much to the cumulative exposure does more recent exposure contribute. And the data on that is basically non-existent. So I think talking about it as latency for an individual who had -- if you were to say here's this man's exposure history and ask me -- occupational health epidemiologist, and you said he was first exposed in 1942, I would say his latency is since 1942. And now you have to address, you know, when did the malignancy actually occur. And if it's already there, then subsequent exposure to the -- when it was there isn't going to have contributed. So you get into the mix of are you going to use years of -- you know, rem years so that earlier you weight earlier exposure versus later exposure because the damage is done and now, over time, that begins to express itself, even if you haven't had subsequent exposure. So I would be more comfortable with adopting the new one. If you had somebody whose

only exposure was in the last two years, that would obviously have to have been a pretty hefty exposure, because even with your 50 rem acute, at one year you only got the 20 percent. So --

DR. ZIEMER: But Henry, isn't that taken care of in the -- by the calculation itself? You calculate the probability contribution year by year, is that --

MR. HENSHAW: Yeah, just for clarifi-- yeah --

DR. ANDERSON: Yeah, but you're reducing -- I mean this, the model you gave was that the one acute exposure, 50 rem, occurred in 1950, or each of those years on up, and then I guess what are -- you assumed there were no other exposures. So if you were to say what is the likelihood of when leukemia occurs in 1980 and the only exposure was in 1950, then you can look at all of the people who had such exposure, and that's what the data from Japan tried to look at, and you see that the leukemia rate in those people drops off because the background rate begins to express itself over and above the rest of it. So if you had multiple exposures, then I would suggest -- or I mean I would feel comfortable saying that something on the line of two, when you're

looking at cumulative issues -- which is what your probability of causation is doing, it's calculating a cumulative exposure -- rather than -- and it's trying to do it by assigning -- assuming that each of the exposures has an independent effect --

MR. HENSHAW: Well, actually if I could just clarify that. IREP does treat each exposure separately.

DR. ANDERSON: As an independent effect.

MR. HENSHAW: Right.

DR. ANDERSON: Which latency -- you know, and the reality is, is it --

MR. HENSHAW: Right, that's correct.

DR. ANDERSON: -- is that an appropriate way and what difference does that make, is there potentiation. So that's why I think you certainly have the flexibility, either as a policy issue or interpreting the science. I mean they're just taking the data and putting different mathematical functions to it, and you can get an S-curve, you can get all sorts of different things, depending on how -- you know, and they all seem to fit pretty well, or as equally poorly.

MR. HENSHAW: Well, I think you raise some very valid points, and I might also add that I got a

new -- I might -- I was running the risk of getting myself into trouble by just using that latency term, but we're using that really more for simplicity, would probably be better if we confined that -- limited that term to time since exposure. Obviously there are different clinical definitions of latency than we're using here for this program.

DR. DEHART: In this case we're discussing an N of one. Considering the two choices that you have, any feel for what the impact would be against the total population under consideration?

MR. HENSHAW: I do not at this time, no.

DR. DEHART: I'm just wondering if it had -- would really have any overall impact, other than on the very occasional individual.

MR. HENSHAW: Yeah, just out of curiosity, though, I was running models -- I was varying the dose for that one acute exposure. And as it turns out -- I think at 26 rem, if I recall correctly -- using those inputs from that slide I put up earlier, the hypothetical claim, one acute dose of 26 rem using that type of radiation -- which I think was gamma photons greater than 250, I think we used -- results in a probability of causation of 50 -- 50 or 51 percent. So that's an issue where this latency

thing could very well play a strong part. Using the current model with 26 rem, the result was 50 or 51 percent. Using the NCI proposed model would likely lower it to a point where it would be below compensation.

DR. ZIEMER: Jim.

DR. MELIUS: Yeah, I had two separate comments. One of the questions that Paul really already asked and sort of procedurally how are we going to deal with these changes and what are -- I think it was significant or major changes --

UNIDENTIFIED: Substantial.

DR. MELIUS: -- substantial, what qualifies and how we set this up and how do we proceed. I would just hope that we could do it fairly efficiently and just -- not to fault what Russ did this time, but that there'd be some sort of a background presentation on at least reviewing some of the science involved, whatever reviews NIOSH may have gotten on this issue in addition to what communication there was from NCI so that for this change, which I don't -- while, you know, it's not, you know, a tremendous change in the IREP program or something, we ought to be able to handle fairly efficiently and quickly, including a discussion of

the -- this policy issue, whatever you want to call it in terms of option number two.

My second comment is a more general one. We've discussed at our past meetings about having some presentations and further discussion at the advisory committee about a number of issues related to the IREP model. There's some age at first exposure, additional occupational exposures and so forth. And it seems that with all the other things to work on and discuss and so forth, those sort of gotten lost from the agenda over time. And I think we ought to come up with some way of at least keeping those issues alive and under discussion 'cause I think they sort of will take some time to discuss among the committee and be able to formulate any recommendations on and so forth, as well as to provide a background for when issues like these do come up where you're wanting to make changes. And one way I thought that might to help move that forward would be to form some sort of a work group within the committee. I threatened Henry last night that we would wait until he leaves and make him chairman, but in all fairness, this morning we'll bring it up before he leaves. But I think it would be a way of maybe at least prioritizing some of

those issues, discussing of ways that we could move forward, some being within a work group, some within the general committee and do it more efficiently, so I'd ask you to consider -- the committee to consider that and we'll -- let's move forward, maybe discuss it or do that later this afternoon.

DR. ZIEMER: Thank you. Other comments on the presentation here? Yes, Sally.

MS. GADOLA: I have a comment on your description of an absolute latency period and the cutoff date of two years or three years, because having worked in the medical field for many years and also having worked in cancer research, as we all know, people vary greatly. And when they go to the doctor, some go as soon as they have any symptoms. Some are getting blood work every six months, whereas others procrastinate and would not go to a physician for maybe many years. So to have an absolute two-year or three-year does not really seem accurate, and I welcome other comments, and I'm also glad that you are evaluating this, also. Because it's bothered me before to have something that absolute.

MR. HENSHAW: Yes, if I could just comment briefly, I think the two and three-year cutoffs for

latency -- minimum latency cutoffs for leukemia and thyroid, as I understand it, were incorporated primarily to be consistent with the NCI-IREP model, having no -- remember that -- well, there was a kind of a rush to get things done at that time and having no hard evidence to the contrary, I believe NIOSH chose the option of consistency with the two models. But I think you're right on that. I think times I've thought about this, it's bothered me, as well. And trying to get to these things as time permits, there are a number of issues that should be examined and reconsidered. This whole time since exposure issue in general, a lot of public comments and expert comment on that, the need to incorporate newer studies of nuclear workers and not rely solely on the Japanese cohort, and all those things need to be looked at. Again, when and if we have time to do that.

DR. ZIEMER: Any further questions or comments?

MR. HENSHAW: Can we go to the public?

MR. SILVER: May I?

DR. ZIEMER: Yes, please.

MR. SILVER: Ken Silver. I've committed a few risk assessments in my time and when those

curves were presented I didn't see a graphical depiction of the uncertainty around each curve. What's your insight or intuition about had confidence intervals been drawn around the two curves, would they be distinguishable?

MR. HENSHAW: Well, yes. For one thing, on the current model there is no uncertainty factored into it, and the current latency adjustment has no uncertainty. The proposed model introduces a new uncertainty distribution to be sampled in the IREP calculations. I don't have a curve showing that uncertainty, but for leukemia it would be 30 -- plus or minus 33 percent around the mid-point, which was I think three years. And thyroid cancer, plus or minus 40 percent around the mid-point.

I think the more important point, though, is that even after factoring in that uncertainty, comparing the two models, the key issue is what is the probability of causation at the 99th percentile. And that's why I point out at that two, three and four-year intervals.

MR. SILVER: On the public policy side, one of the lead sponsors of this legislation, Senator Bingaman, has a very nice way of explaining the legislative intent when he meets with people around

here, and he refers to the use of a generous error bar. So if you take that as the guiding principle, one could go back to your two spreadsheets with selected red numbers and fold them into one composite spreadsheet of all red numbers using plaintiff-friendly assumptions for the probability of causation at each latency interval.

MR. HENSHAW: I'm not sure if I --

MR. SILVER: You gave us a graphical depiction of the probability of causation under the current and proposed latency functions. Right?

MR. HENSHAW: Yes.

MR. SILVER: And you highlighted the plaintiff-friendly probability of causations in red.

MR. HENSHAW: Oh, on the table, right.

MR. SILVER: Yes.

MR. HENSHAW: Yes.

MR. SILVER: So given the guiding public policy rationale for this is use of a, quote, generous error bar, one could create a third table which is --

MR. HENSHAW: Taking the higher values, the red numbers?

MR. SILVER: Yeah, so I would label that option 1(b) and want to look further into how 1(b)

compares to two in terms of how generous it is towards the plaintiff -- or claimants, I'm sorry.

MR. HENSHAW: Yeah, just a couple of comments, though. I think -- that's sort of how I'm thinking of option two now, which is (inaudible). But also bear in mind that that hypothetical claim was one set of inputs. There are an infinite number of inputs that would result in different values at each time since exposure for each of the two different models. I did not choose this set of inputs for any particular reason. There was no pre-determined goal that we hoped to achieve or anything like that. It's just one set of inputs. Running it on others, you know, could produce something slightly different.

MR. SILVER: Thank you.

MR. ELLIOTT: I think what Ken has brought up is really the crux of the problem here, and I'd like to go on record to say that we certainly agree with Senator Bingaman in his take on what the Congressional intent was here. And it's been our intent, as well, that we use science to the fullest advantage that we can in this program. And when that fails us, decision has always been to be claimant-favorable, and that's what we're going to

continue to do.

MR. HENSHAW: If I could just follow up on that for a second, mentioned that we're looking at newer studies and we're considering adjusting these models as time goes on. Now that's a dual-edged sword, as well. It may -- very possible we could look at some of this new data and it could be significantly less claimant-friendly if we incorporated that. We'll have some policy decisions to make at that point in time, should that develop.

DR. ZIEMER: Okay. Thank you, Russ. I think that's all the questions we have today.

UNIDENTIFIED: One quick question.

DR. ZIEMER: I'm going to limit questions from the audience. If you have comments during the public comment period, we can do that. Normally we don't have public input till then, anyway, so we're behind schedule so we're going to move ahead on the agenda.

REVIEW AND APPROVAL OF DRAFT MINUTES

The next session is the Board working session. We're going to begin with the minutes of the sixth meeting. We now have had a chance to read those. What I'm looking for are substantive changes as opposed to grammatical and minor changes, which

you can submit individually in a marked-up copy.

Let me ask if any of the Board members have substantive changes to the minutes of the sixth meeting, which is the August 14th or 15th meeting.

Yes, Mike.

MR. GIBSON: The one comment I would have is I was on the conference call and I think it's mentioned that there was two potential new appointees that were on the call, and I was just mentioned as a member of the public, I believe.

DR. ZIEMER: Where is that on the -- can you give us a page number for that?

UNIDENTIFIED: The seventh meeting, page two.

UNIDENTIFIED: The August 27th meeting.

DR. ZIEMER: We're still on the August 14th --

MR. GIBSON: Oh, I'm sorry.

DR. ZIEMER: We'll come back to that, Mike, if you would, in just a moment. On the August 14th and 15th meeting, any substantive changes?

(No responses)

DR. ZIEMER: There are none? I'd like to ask for clarification on page four. The SEC work group identifies only three people -- page four of

the -- regular four. Henry, weren't you involved in that?

DR. ANDERSON: Yeah.

DR. ZIEMER: Yeah, so we need to add your name to that, and I was involved, as well, so we'll add our two names to that work group.

MR. GRIFFON: Again, I just -- one -- on the executive summary of the meeting -- I'm sorry, page five of seven, and that's as far as I was able to review, actually, but the -- on the very top of the page, the first bullet talks about the blind reviews, and it says in which the review will proceed from the IREP data. It's actually from the raw data, without the IREP input file established by NIOSH. That was the intent of the --

DR. ZIEMER: So your suggested correction is to replace the IREP with raw?

MR. GRIFFON: Raw data, and then add on possibly -- well, I guess that -- that suffices, I guess, just raw data, you know. They don't have the input file to IREP.

DR. ZIEMER: Any objections to that change?

UNIDENTIFIED: No.

DR. ZIEMER: Other changes?

MR. ELLIOTT: I'm sorry, can we go back to

that? I didn't understand clearly what you're doing there. It's on the first bullet --

MR. GRIFFON: First bullet, yeah, the --

MR. ELLIOTT: Blind category in which the review will proceed from the -- I think what you're talking about, though, is not the IREP data, you're talking about the raw case file information.

MR. GRIFFON: Right, raw case file information. Right, I wanted to delete IREP.

MR. ELLIOTT: You're not going to have IREP.

MR. GRIFFON: Right, delete IREP and replace raw case --

DR. ZIEMER: So we call it raw case --

MR. GRIFFON: -- raw case --

DR. ZIEMER: -- file --

MR. GRIFFON: That's right, raw case file data.

DR. ZIEMER: Is that agreeable?

UNIDENTIFIED: That's agreeable.

DR. ZIEMER: Other changes?

MR. OWENS: Dr. Ziemer?

DR. ZIEMER: Yes, Leon.

MR. OWENS: On page 15 under public comment, Mr. Bruce Lawson, seventh line down, the sentence begins with Mr. Tudor.

DR. ZIEMER: Yes.

MR. OWENS: I'd like for the record to reflect Mr. Lawson there. I think that needs to be changed 'cause that's --

DR. ZIEMER: Mr. Lawson now works --

MR. OWENS: Yes, sir.

DR. ZIEMER: Thank you. Without objection, we'll make that change. Any others?

(No responses)

DR. ZIEMER: Then I'll ask for a motion to approve the minutes with those changes and with the caveat that minor grammatical changes can be submitted individually to the recorder.

DR. ANDERSON: I'll make that.

MR. GRIFFON: Second.

DR. ZIEMER: Motion's been made and it's seconded. Further discussion, all in favor say aye?

(Affirmative responses)

DR. ZIEMER: All opposed, no?

(No responses)

DR. ZIEMER: Abstentions?

(No responses)

DR. ZIEMER: Motion carries. Thank you. Then we move to the minutes of the conference call, which was on August 22nd. Are there any additions

or corrections to the minutes of the conference call?

MR. ELLIOTT: I think -- I appreciate Mike coming up with this error that he found here. It should read Mr. Mike Gibson and Mr. Leon Owens, new ABRWH members approved by the White House, and then we should move Mr. Frank Morales down to members of the public, right below that. And his affiliation is GAP. See what I'm saying?

DR. ZIEMER: Is that agreeable then?

UNIDENTIFIED: Yes.

DR. ZIEMER: Without objection, we'll make that change.

Any other corrections? I'm going to suggest one change on page five where it's headed Attachment 2. It says Dr. Andrade, who had to leave the conference early, voted in favor. I think procedurally Dr. Andrade could not have voted since the motion was not before us at the time. I'm going to suggest that we simply word that voiced his support for the attachment.

DR. ANDERSON: That's what it -- it's already been changed.

DR. ZIEMER: Okay, so they've already --

DR. ANDERSON: Yeah.

DR. ZIEMER: It sounds like you have the copy that I already marked up. This is the one that came from the restaurant in Omaha, by the way, so --

DR. ANDERSON: You can see the mustard stains.

DR. ZIEMER: Okay. Well, the original copy said that he voted, so you didn't know that.

DR. ANDERSON: No, I didn't know that.

DR. ZIEMER: I shouldn't have told you. Are there any other corrections then? I won't raise any of mine; they're already in there. Henry?

DR. ANDERSON: In attachment one, is this supposed to have been the final or just the draft?

DR. ZIEMER: I'm sorry, where are you?

DR. ANDERSON: On page seven we have DOE number -- a bunch of question marks. I assume we didn't send it that way. This is just the draft?

DR. ZIEMER: Yes, this may have been confusing. What you have attached are not the final versions. If you looked at the final version, the things that were sent to the Secretary, they are not these. These are the things that we were working with at the time of the conference call. Is that clear to everybody? These do not constitute the recommendations to the Secretary in their final

form.

MR. ELLIOTT: They're so mentioned in the text of the minutes that way, attachment 1 is.

DR. ZIEMER: But for your own benefit -- and maybe we should identify that, report attachment one draft letter to the Secretary. Shall we do that?

UNIDENTIFIED: Yeah, that would be --

UNIDENTIFIED: -- a good idea.

DR. ZIEMER: And likewise, attachment two is draft transmission letter, and attachment three is draft rule comment attachment. Is that agreeable with everyone?

UNIDENTIFIED: Yes.

UNIDENTIFIED: Yes.

DR. ZIEMER: 'Cause those were at the time the drafts we worked with, but not the final copies.

UNIDENTIFIED: I didn't think so.

DR. ZIEMER: In fact, I started to mark those up, thinking they were wrong and they were what we had --

MR. GRIFFON: Attachment three?

MR. ELLIOTT: There are only two attachments.

DR. MELIUS: We never got an attachment three.

DR. ZIEMER: I'm sorry, I don't know. Where did I put attachment three?

UNIDENTIFIED: It was the menu from the restaurant.

DR. ZIEMER: I have something called report attachment three.

UNIDENTIFIED: Attachment three is the --

DR. ZIEMER: Report attachment three, rule comment attachments.

MS. MUNN: Well, it was on the web.

DR. ZIEMER: It was page nine of what I originally downloaded, but it may have --

UNIDENTIFIED: It just didn't get copied into our books.

DR. ZIEMER: Do you have the general comments and specific comments on the rule?

MS. MUNN: Yes, I got them off the web.

DR. ZIEMER: It's starts with a paragraph called non-SEC cancers?

MS. MUNN: Yes.

DR. ZIEMER: Okay, it just has a different title on it then. What's at the very top of it?

MS. MUNN: Report attachment number three.

DR. ZIEMER: Exactly, that's what I'm saying, report --

MR. GRIFFON: But it's not with this package. She got it off the web --

DR. ZIEMER: Oh, okay. There is attachment three and it will say draft rule comment attachments. It's the document we worked with at the --

DR. ANDERSON: Is it referenced in the text? I don't see...

MR. GRIFFON: I didn't see it referenced.

DR. ZIEMER: Well, you see report attachment two was the cover letter, and then attached to the cover letter were the comments. These --

DR. ANDERSON: Oh, okay.

DR. ZIEMER: So these are the comments in draft form which are attachment three.

DR. ANDERSON: I got it, okay.

DR. ZIEMER: Some of you have them if you downloaded them from your e-mail. They apparently didn't get into the final copy here. Everybody understand?

UNIDENTIFIED: Yes.

DR. ZIEMER: You do have a copy of them from earlier before, so -- I mean that's what we had, so we're not asking you to change that because that's what we had.

Okay. Are there any other corrections?

(No responses)

DR. ZIEMER: Motion to approve these minutes with those minor changes and with the caveat that grammatical changes can be submitted?

DR. MELIUS: I so move.

UNIDENTIFIED: And second.

DR. ZIEMER: It's moved and seconded. Further discussion?

(No responses)

DR. ZIEMER: Then all in favor of approval of those minutes say aye.

(Affirmative responses)

DR. ZIEMER: Opposed say no.

(No negative responses)

DR. ZIEMER: Ayes above the noes, as they say. Oh, I didn't ask for abstentions.

(No responses)

DR. ZIEMER: No abstentions.

BOARD DISCUSSION/WORKING SESSION

DR. ZIEMER: Okay. Now I think, Mark, we need to -- you're not ready for us to move to your -- Okay. Jim, you had an idea you wanted to raise during the working --

MR. GRIFFON: I think that should go first,

anyway.

DR. MELIUS: Yeah, I just thought we should discuss the -- make some recommendations on conflict of interest procedures regarding the ORAU contract, and particularly the issue of how will the claimants be informed about the people that are working on their dose -- the contractor personnel who are working on their dose reconstruction. So what -- I don't know if Cori had time to -- or able to obtain -- there was some documentation that was available on the web site that we had talked about might facilitate the discussion.

DR. ZIEMER: Let's take a five-minute comfort break while they get that.

(Whereupon, a recess was taken.)

DR. ZIEMER: The document associated with Oak Ridge Associated Universities and conflict of interest has been distributed. Does everyone on the Board have a copy of that material? It should be at your seats.

Okay, Jim, are you ready to proceed with your questions here and your comments?

DR. MELIUS: Yeah. And Larry or Jim Neton, whoever, can correct me if I'm -- don't understand. My understand--

DR. ZIEMER: And also before you begin, might I ask, is Richard Toohey still here? Rich, could you sort of be on deck in case there was specific questions concerning ORAU that we might need to ask you about, too. Is that agreeable with --

DR. MELIUS: Yeah, yeah, yeah.

DR. ZIEMER: So if you'd kind of be on deck. Okay.

DR. MELIUS: And I guess my question -- my understanding was that the document we passed out was sort of Oak Ridge's proposal or their proposed policy for dealing with conflict of interest, and as Jim Neton was presenting it, it's sort of up to NIOSH to adopt this -- or implement this as part of this program, along with whatever additional restrictions or whatever that NIOSH would place on this. And what I thought it would be -- and so when Jim Neton was making his presentation yesterday there were some sort of open items still where particular issues hadn't quite been decided how they would be implemented. And I guess what I was trying to get at is as a Board we should -- maybe now's the appropriate and best time for us to make recommendations to how we would recommend that these

situations be handled, these particular instances be handled, and then NIOSH can go ahead and do the appropriate implementation from there. At the meeting yesterday we had initially discussed sort of reviewing it after the fact, but that's going to be between meetings and I think this may just be a better way of going --

DR. ZIEMER: So the suggestion then is to take -- I think you could characterize this as Oak Ridge Associated Universities' proposed -- this came out of their proposal, would be my understanding -- proposed policy that -- and -- this is the plan and this is now available for the Board to --

DR. MELIUS: Right.

DR. ZIEMER: -- review and react to and raise questions on and --

DR. MELIUS: And actually --

DR. ZIEMER: -- voice any concerns.

DR. MELIUS: And actually Jim Neton presented most of this.

DR. NETON: Yeah, I presented some of it. I didn't present the entire plan, but I did present the -- I think there's nine bullets under section B of that plan that talks about to avoid potential -- on the bottom of page 3, to avoid potential or

actual perceived conflict of interest -- I went over those three, four, five, six, seven, eight, nine bullets and really the only two of those bullets that I indicated there was some wiggle room, if I could use that word, the last two items which specifically address the transparency issue. And those were whether we were going to actually in total incorporate the forms that the contractor employees filled out on the web as electronic images or we would have some substantial similar basis of those forms on there. We were somewhat concerned about having signatures and those sort of things on the web site.

And I believe in the last one we talked about providing biographical sketches of the dose reconstructor at the time the dose reconstruction was issued, and we felt that there may be a better time to do that, which would be at the time the dose reconstructor was assigned. And also whether that -- it would be more appropriate to be a biographical sketch or some other CV or bulletized listing of their employment history or something to that effect.

I think those were the two issues that I was talking about that I allowed some wiggle room on,

and correct me if I'm wrong.

MR. ELLIOTT: If I can speak, I think you're right, Jim, but I would also add that this is the plan and I think both ORAU and NIOSH would welcome any advice that the Board has, any recommendations that you have about the entire plan, not only just those two remaining unattended issues at this point in time. We want your input into those, but anything else that you see here, I'm sure ORAU -- the ORAU team would appreciate that, and I know we would.

DR. NETON: The entire conflict of interest plan is subject to some negotiation. It is not -- even though the proposal has been incorporated into the contract, the NIOSH contract, I believe the state conflict of interest plan was part of the business proposal, so it would not require a contract modification to alter any of these elements at this time.

DR. MELIUS: And I guess what I'd like to initially focus on is the transparency issue and it would be -- I guess to start the discussion off, it would be -- my recommendation would be that this attached form or some equivalent to it, which is the last page of proposal, that type of information be

-- one made available to each claimant once a person from the contractor is assigned. And that a --

DR. ZIEMER: At the front end?

DR. MELIUS: At the front end, that that be provided to them, that this is your person that you -- has been assigned to your -- do your dose reconstruction and this is the background of this -- of that person. Now whether -- wanted to add some additional educational information I think might be helpful. I mean it's nice to know what the background of the person is, but this has been the -- their previous jobs. Along with some statement that if you have some concerns -- if you as the claimant has some concerns about any potential conflict of interest or bias on the part of this person, please contact the NIOSH person who has been assigned to monitor your case.

DR. ZIEMER: At this point this is kind of a suggestion?

DR. MELIUS: Suggestion, yeah.

DR. ZIEMER: Not necessarily a formal motion, but I think, Jim, you're asking for some reaction from the rest of the Board --

DR. MELIUS: Correct, yeah.

DR. ZIEMER: -- members. Do you generally

agree with this kind of an approach?

DR. MELIUS: Uh-huh.

DR. ZIEMER: Not necessarily the details of the form --

DR. MELIUS: Yeah.

DR. ZIEMER: -- but the concept, where the thing provided to the applicant or the supplicant would be the -- not only the disclosure information on potential conflicts of interest, perhaps some additional biographical information --

DR. MELIUS: Correct.

DR. ZIEMER: -- and qualifications. Is that --

DR. MELIUS: Correct, yes.

DR. ZIEMER: -- correct? And was there --

DR. MELIUS: That was it.

DR. ZIEMER: That was it.

DR. MELIUS: Along with a statement saying that if you have --

DR. ZIEMER: Have concerns --

DR. MELIUS: -- concerns or whatever that --

DR. ZIEMER: -- (inaudible) -- yeah. Okay. Now just react to that, pro or con.

DR. ANDERSON: Yeah, I would support that. I think it's much better as part of a kind of an

administrative process to identify who the person is, let the claimant know about the conflict of interest statement, information about that person, offer them the opportunity if they have concerns to voice them, rather than to wait potentially till after it's all done and then the person is unhappy and so then they raise issues that they didn't think of early on, so I think it would be better to do it right up front with the claimant.

MR. PRESLEY: One thing I would comment on is the biographical sketch on the person doing the work. Make that within reason. Sometimes you see these things and they're four or five pages long, and they can be more misleading than they can be good on some of these people.

DR. ZIEMER: Your suggestion is that a nice concise biographical sketch, just --

MR. PRESLEY: A one-pager.

DR. ZIEMER: A one-pager. Thank you. Other comments? Wanda's next.

MS. MUNN: I would prefer to see not even a one-page. I would like to see an eleven-inch by eight-inch -- an ordinary page cut in thirds.

DR. ZIEMER: I don't want this to be overly descriptive, but --

MS. MUNN: No, no --

DR. ZIEMER: -- I think the idea is to keep it short --

MS. MUNN: But the reason --

DR. ZIEMER: -- but to cover it, yeah.

MS. MUNN: The reason I say that is very simple. Every additional page that you send to folks weighs them down. Nobody wants to get any more paper than they absolutely have to have. And on a third of a standard sheet, you can put an individual's name, their very abbreviated CV and perhaps specific projects with which they have been involved, and a contact -- as Jim said, if you don't like this, contact this person at NIOSH. That can be done very simply and as an insert to what goes, rather than a page that becomes a part of a document that they have to deal with. In my personal view, I would much prefer to get something of that sort I could pick up and read -- ah, this is the person who's doing this, set it aside somewhere else -- by my phone, if I wanted to.

DR. NETON: Could I make a quick comment in response to that? I'm a little concerned -- with these biographical sketches, I just want to point out I think what we're trying to do here is to point

out employment histories that would be involved and perceived conflict of interest. I'm concerned that if we start fleshing out detailed biographical sketches, claimants will start shopping around for qualifications to do dose reconstructions. And I think as Larry indicated yesterday, that is really not an issue here. If they're -- we have deemed them qualified by the contract and what the specifications of the contract were, so I think -- I think it should be limited really to the biographical sketch that is relevant to conflict of interest issues. That's -- at least my opinion.

DR. ZIEMER: Other comments? Jim, as I understand what you're saying, then you would only include that part of their employment record that was pertinent to establishing the issue of conflict of interest, or lack thereof --

DR. NETON: I think that's --

DR. ZIEMER: -- and not every job or every degree or every --

DR. NETON: Right. I mean I could see someone saying I want someone with a Ph.D. to do my dose reconstruction because they're more qualified or something like that, and I don't think that really should be an issue --

DR. ZIEMER: Yes.

DR. NETON: -- in these cases.

DR. ZIEMER: Other comments from Board members, pro or con? What I'd like to see here, unless the Board wants to do this differently, is get a sort of a sense of the Board for the benefit of the staff and for the benefit of ORAU. You may want to make a formal motion, but otherwise the sense of the Board may be all we need at the moment. And the sense of the Board requires that we have more than one comment, otherwise it's the non-sense of the Board.

MS. MUNN: I do, however, feel very strongly with respect to something someone said earlier. No one's signature, Social Security number, home address or names of people -- members of family should ever appear on anything --

DR. ZIEMER: And that would not be needed, I don't believe. Is that correct, Jim?

MS. MUNN: No.

DR. ZIEMER: That's not needed. Right? Thank you. Mark?

MR. GRIFFON: Yeah, I guess I'm just -- I'm trying to see both sides of this on putting out the work histories of the dose reconstructioners --

reconstructionists. My feeling -- the other -- the other -- flip side, I guess, potentially here is that if you put out a brief bio sketch only covering the conflict of interest areas, I know in this day and age it's very easy to do internet searches and they can -- they can start to piece together things and have more questions than answers. And I'm wondering if it makes more sense just to be -- have an open book approach at the front end. I didn't consider this whole shopping around question, but -- you know, as I understand that comment, but I can just see people, you know, go get the name -- if you only give them a little bit, they can -- they can do internet searches and say wait a second, they didn't even tell me they were involved in this project and this project. You know, this -- this isn't very open -- isn't a very open process, so I guess that -- that's another concern I would have. I'm --

DR. ZIEMER: Thank you. Further comments? Yes, Henry?

DR. ANDERSON: Kind of in between you could have what is the basic description, a statement about conflict of interest and that it's been reviewed and these people have been vetted and we don't believe there is, but here's some information.

If you'd like a more detailed history about the individual, contact your contact person to get a -- rather than have, you know, a long, involved CV. And if people wanted to have more detail, they could obtain it if they want it but it would not be something that's sent out routinely to everybody. But I think clearly we need to have who that person is identified up front, something about them, so -- and a statement that, you know, conflict of interest has been reviewed and, you know, if it's a -- NIOSH review has been done, as well, some understanding that this person has been vetted, is assigned to your case. No conflict was identified. However, if you have concerns or if you'd like more information about the individual, here's how you go about getting it so that would avoid doing a internet search and saying oh, this person belongs to such and such association or a professional group and I'm worried that that group is -- you know, so you --

DR. ZIEMER: You're suggesting a kind of middle ground --

DR. ANDERSON: Yeah.

DR. ZIEMER: -- where you don't --

DR. ANDERSON: Most people don't care, but if they really want information, they need to have a

mechanism, but not have it be for the whole world on the internet or something like that.

DR. ZIEMER: Any other comments?

MR. OWENS: Dr. Ziemer?

DR. ZIEMER: Yes?

MR. OWENS: I agree with Dr. Melius. I think it's also very important that -- that trust is developed for the claimants, and we all know that their issues relative to Oak Ridge Associated Universities and their connections with the DOE. I think that if we provide information up front, that will in some small way establish somewhat trust amongst the claimants in the entire process.

DR. ZIEMER: Yes, Richard.

MR. ESPINOSA: With what Mark and Henry are saying on that, I absolutely agree. I think there needs to be an open book. Maybe not everything put up front, but in a way for the claimant to contact the worker to get that open book, if need be.

DR. ZIEMER: Thank you. Mike, comment?

MR. GIBSON: I'm certainly not one to question the integrity of any internal dosimeters or anything else, but in a dose reconstruction, typically it goes through a peer review by another internal dosimetrist, so there could be someone who

sees -- knows that a particular internal dosimetrist has done their case at the site, yet there may be someone that's done a peer review assigned to do the dose reconstruction for NIOSH, and how would that be made --

DR. ZIEMER: I think that's a point we need to hear from either Jim or Larry. You want to speak to that issue?

DR. NETON: I think -- I'm not sure I quite understood. One person did their dose reconstruction at the site, is -- you were saying -- while they were employed there? If they were, they would be prohibited from doing that.

DR. ZIEMER: You're asking about the primary dose reconstructionist for NIOSH. Is that what you're asking?

DR. MELIUS: There's other reviewers within the contract. ORAU will have other people supervising --

MR. GIBSON: I mean -- now there's been -- MJW's had a contract to do dose reconstruction, but typically the ID who does the dose reconstruction, their work is then done -- peer reviewed by another internal dosimetrist, and so they could also have potential conflict there if they're assigned to do

the dose recon of --

DR. NETON: That's correct. I believe that the supervisor was also identified in the dose reconstruction report, of who actually was the supervisor of the person that reviewed that dose reconstruction. Now we did not propose -- or I don't think we're discussing sending the biographical sketch of the person who will ultimately supervise or review the dose reconstruction, but I guess that's an open-for-discussion item.

MR. ELLIOTT: But the conflict of interest plan does say that a reviewer of a dose reconstructionist would not be conflicted, as well.

DR. NETON: That's correct.

MR. ELLIOTT: They would prevent that from happening. But I think what I hear Mike asking for is to make sure that the claimant knows who that reviewer is up front -- I assume up front.

DR. NETON: Right.

MR. ELLIOTT: You wouldn't want to know at the end of the process. That gets at what we heard earlier.

DR. NETON: Yeah, that would require -- and I guess that mechanism has not been worked out as to

whether the super-- the reviewer would be identified at the time the dose reconstruction was assigned, but that certainly could be made the case. I mean we really haven't --

MR. ELLIOTT: And then there would be --

DR. NETON: -- discussed that.

MR. ELLIOTT: -- a third reviewer that would be a --

DR. NETON: The NIOSH staff.

MR. ELLIOTT: -- NIOSH person to -- you know.

DR. NETON: So there are three people involved in this process, at least.

DR. ZIEMER: There will even be cases where the Board is reviewing some, but in all the cases there will be, in a sense, a kind of certification that there are no conflicts of interest. I mean that will have to be true of anything that we review as quality control, you know. And so where does that stop? Certainly the primary reviewer, that might be a pertinent point. You know, can you tell the person up front or do you know up front who that's going to be, and if you do, it would seem there'd be no reason not to make that known.

DR. NETON: I suppose for transparency

issues one could include this type of information in the letter that goes to the claimant at the time the dose reconstructor was assigned, some brief summary of what's in the conflict of interest plan itself that discusses those issues, that the supervisor who will be reviewing this is also one of the following constraints and -- and indicating that the conflict of interest plan does exist that one could read on the web, or even -- you hate to include these things because you send 8,000 of anything out, it becomes a lot of paper. But something -- you know, or to indicate that it is available and we'll provide a copy upon request, those kind of things.

DR. MELIUS: I think as we found with the -- some of the comments yesterday about the questionnaires, there's a lot of confusion, what is expected from people, these -- in filling things out in the process. And I think a good letter up front -- I think Larry sort of outlined it. You know, look, these people are qualified. We've chosen qualified people. Yes, we have, you know, concerns about conflict of interest. We think it's very -- you know, that people have gone through a process. There is a policy. The policy's being followed. However, we want to make sure you're comfortable and

for these reason we're providing you this additional information about the person doing the dose reconstruction, their primary supervisor/reviewer, and that this -- you know, if you have any concerns or questions about this information, you know, call the NIOSH person that's been assigned to oversee this case. And I think it could be straightforward. Then as an additional step, which I guess we can discuss, what information ought to be available on the web and then -- plus generally available 'cause not everyone has web access, but people ought to know that if they want to have a better understanding of the -- for example, the conflict of interest policy ought to be on there with some explanation on how it's being implemented so people can get that, or they can request it directly from NIOSH. And I think that would -- I think that would make sense.

DR. ZIEMER: Any other comments? Roy?

DR. DEHART: I have a comment, but it's not on the letter, per se, but on the document. Go ahead to that?

DR. ZIEMER: Yeah.

DR. DEHART: On page three there's a listing of activities which must be revealed. I'm curious,

however, when I look at the fifth bullet, which reads wherever and where an individual conducting dose reconstruction for ORAU team has acted as an expert witness on behalf of DOE or a DOE contractor. What is missing there is or plaintiff or claimant. I was wondering why that was omitted. There's two sides to bias.

DR. TOOHEY: I can answer that. Basically the COI plan we submitted was really based on a letter that I believe Mr. Miller sent to Joe Gilchrist a while ago for the government accountability project outlining what they considered the conflict of interest issues were. And that was taken right out of there. And I agree, it's a one-way street from that point, acting on -- we would certainly not consider someone who had acted on behalf of a plaintant (sic) to exhibit the conflict of interest in the claimant-friendly sense of doing a dose reconstruction. But again, we're open to your suggestions.

DR. DEHART: I think in all fairness to both sides, it would be appropriate to put that in there.

DR. ZIEMER: That's a view, and we don't know whether that is a widely-held view or not, but -- Gen Roessler.

DR. ROESSLER: I agree with that view. In fact, I was going to bring it up. I think it needs to be put in there because this is only one-sided.

DR. ZIEMER: Mark?

MR. GRIFFON: Can I ask, since Richard Toohey made it clear that Richard Miller was the author and he's right here, can I ask for an explanation from Richard?

DR. ZIEMER: Sure. Richard, could you --

UNIDENTIFIED: Which Richard?

DR. ZIEMER: Richard Miller, I think, at this point.

MR. GRIFFON: I know, he was anyway, so I figured I'd bring him up.

MR. MILLER: The rationale associated with looking at the defense posture of an expert is rooted really in legislative history. The purpose of the legislation was to overcome what had been historically the government's posture to spare no resources in defending claims. And the government had -- and as well-disclosed in a number of discrete cases and through Congress -- had made out I think a pretty clear record about how -- the ways in which the entire DOE system had been turned on its head to fight these claims. And the entire intellectual

resources were deployed in defending these claims, and millions would be spent on claims that would settle for a fraction.

But the question was, in terms of who is coming in and bringing a bias, if you're defending the -- if the purpose of this is a remedial program, as opposed to a program which was simply constructed to weigh the equities on both sides, and this is not a program -- that's why we have things like benefit of the doubt that are sometimes given to claimants, where you wouldn't do it perhaps in a dosimetry program, but you will do it for purposes of dose reconstruction. Here what we're -- we're not dealing with an -- a court of equity. We're not dealing with equitable balances. We're dealing with a remedial circumstance.

So my concern I guess is is that at the point at which you -- and I'll be up front, you know. We had Rob Hager here yesterday who litigated the Harding case, right, 15 years. Oak Ridge Associated Universities was associated with defending the litigation in that case. Donna Kreigel* was brought in as an expert witness to defend on the epidemiology. And so the question becomes if you're going to look at a remedial

program as opposed to a balancing of equities, the remedy is let's make sure that the people who have spent their careers fighting this be out of the room. And this notion somehow that we have to -- well, we should also add in those that might have worked on the plaintiff's side and that they're going to bring a bias to it. I mean I think that's not -- that's not the risk in this program.

The risk in this program and the risk that has to be guarded against is the risk that the same institutional forces will continue to replicate under the umbrella of this compensation program. That was -- that was the safeguard, at least from our perspective, in offering that -- for whatever it's worth.

DR. ZIEMER: Thank you for that input. **DR. DEHART:** Could I respond?

DR. ZIEMER: Roy?

DR. DEHART: I thought that the basis of what we are doing is based on science. And when science fails, we will move toward the position of the employee, the worker, and not a litigative kind of activity here.

MR. MILLER: I mean I think -- I think you're -- I mean the hope was, Dr. DeHart -- the

hope was that this could be a science-based program, recognizing that all the science won't be there. That's why we're dealing with things like special cohorts and so forth. That's why in fact we're dealing at the 99 percent confidence interval instead of dealing at the 50 percent confidence interval. Those were all efforts I think by Congress to try to remedy what was wide uncertainty in the science, wide uncertainty in what we know about radiation epidemiology, wide un-- Right? I mean there's tremendous uncertainties here and the effort was to be remedial in these circumstances. I mean -- so from that perspective, this is not simply just a science-based program. It's a remedial program.

You can read the preamble to the Executive Order and the preamble to the legislation, clear -- make it very clear that this is remedial in character, not a science-based program designed to balance equities.

DR. ZIEMER: Other comments? Gen? Thank you.

DR. ROESSLER: I don't understand what the objection would be to adding to the statement or putting another bullet in there that would describe

what Roy is suggesting. You know, a comparable statement that would be kind of like the other side. It doesn't seem to me there should be any objection to that.

DR. ZIEMER: I think that Richard Miller's explanation was in fact addressed to that in the sense that it appeared that things were heavily weighted the other way and -- but nonetheless, it's an issue that perhaps needs to be aired further. Henry?

DR. ANDERSON: Yeah, I think there's a couple of issues. One, you have to keep in mind that there's a claimant out there and in that sense it's a plaintiff, but it's a claimant filing and what we're doing is trying to design a program to convince that person that they're going to get a fair shake. And to say, you know, if you were to ask them would you like an expert who has been a consultant to, you know, workers and other attorneys, they would all say well, that's probably a person that I'm going to have confidence is going to give me a fair shake. So you know, I think part of it -- you know, we have to keep in mind, this isn't a letter going to DOE saying we want you to be sure -- in that balancing, so I don't have a problem

with the way it's worded 'cause I think Richard said it.

On the other hand, I'm not sure that there's going to be -- you know, that it's sort of a moot issue. I don't think there's many of those individuals that are going to be out there that are going to come into this program or on the list of 90 that they already have. So -- and I would assume somebody will look at that. So you know, we can argue about it, but I think in reality it probably is not going to be an issue.

DR. ZIEMER: Just -- I'm thinking off the top of my head here a bit, but it appears to me that in the case of those who are mentioned here are individuals who had all been tied in with the agency that's involved here, and so the conflict of interest is a little more obvious.

On the other side, the -- I assume these would be individuals who were working on a particular case and therefore were, in a sense, representing an individual. And obviously if that individual were being somehow considered for recompense under this program, there would be a clear conflict anyway. Whereas it's not so obvious that if they somehow reconstructed a dose for

somebody else, that the -- it's not clear to me that the conflict is quite as obvious. That's my only thought on it. The fact that they were opposing DOE, let's -- if I can use it in those terms, it seems to me -- at least theoretically -- does not inherently mean that they are always biased against DOE. Some might argue in practice that's not always been the case, but I think at least conceptually it's -- the two sides are not the same, is how it appears to me. I'm open to other views on this.

MR. ELLIOTT: Is it possible to be perceived that a person who served on behalf of a plaintiff is going to work harder on a dose reconstruction than somebody who didn't? And does that then present a perceived conflict of interest and is that an issue? Is that what's -- is that what's behind, you know, maybe the basis of adding that language to this section?

DR. DEHART: Well, certainly that's a possibility, but that isn't the point. I was looking for balance. The same question could be asked of someone who had been a member -- a DOE staff. Are they not going to be fair and objective?

DR. ZIEMER: Further comments pro or con on this or any others? Wanda, thank you.

MS. MUNN: It seems that rather than get tangled up in additional language, the same end that Roy suggests could be achieved by removing the phrase "on behalf of DOE or a DOE contractor" and just simply say "have worked as an expert witness with respect to worker compensation claims or lawsuits". Would that not serve the purpose?

UNIDENTIFIED: That's what Roy's proposing.

DR. ZIEMER: I'm going --

DR. TOOHEY: May I comment on that? I think that might throw a lot of people out of our current pool, including Dade Moeller, Sr. We specifically, you know, went with the DOE in there because a number of people have been involved in worker suits against nuclear power plants or VA, whatever. I myself, not in suits, but I did some testifying before the Illinois Pollution Control Board on the issue of the standard for radium in drinking water, so...

MR. GRIFFON: And believe for MJW, as well, I believe.

DR. ZIEMER: I'm going to suggest that we continue this discussion after lunch. We do want to allow time for public comment session. We are approaching the noon hour. We have one individual

that has requested to speak prior to lunch and that's Phillip Scofield, so without objection, I'd like to go to the public comment period and ask Phillip Scofield now to address the Board.

PUBLIC COMMENT PERIOD

MR. SCOFIELD: Thank you for this opportunity to address the Board and thank you for all coming here to Santa Fe. Primarily I would like to address some issues with the IREP and the way it is. I don't necessarily have all the answers, but I do have some concerns.

Large-scale epidemiological studies of U.S. Department of Energy workers have been underway since 1960's. Despite the increasing availability of information about long-term follow-up of badge-monitored nuclear workers, standard-setting bodies continue to rely on life span studies of atomic bomb survivors as a primary epidemiological basis for making judgments about hazards of low level radiation.

Additional, faith in the internal and external validity of studies of A-bomb survivors has influenced decisions about the design, analysis, interpretation of many worker studies. A systematic comparison of the LS* in worker studies in terms of

population characteristics, types of radiation exposures, selection factors and dosimetry errors suggest that the priority be given to dose response findings from the LS is no longer warranted. Evidence from worker studies suggests that excess radiation-related cancer deaths occur at doses below the current occupational limits.

Low dose effects have also been seen in studies of childhood cancers in relation to fetal irradiation. Dr. Charles Land, in talking about the revision of the 1985 National Institute of Health radiological tables, he even states that when they're updating them from the BEIR III report to the BEIR VII includes new data from the atomic bomb survivor dosimetry study. The studies were then used for studies applied to the U.S. population. There again is major differences in dosimetry. The majority of the Japanese survivors had long-term -- I mean short-term very high exposures versus long-term chronic exposure.

Last, the other problems I've -- have with the IREP is the way it's going to -- how they're going to handle these problems and that is use of site profiles for dose reconstruction. In many areas, this is going to have tremendous headaches

and it's going to be very questionable, at best. Just to give an example, you have some areas where a person could be working in there. If you use their co-workers' data, this person's on a different type of project than they are, even though they save -- have the same room. One person's getting high neutrons, one person's getting high gamma. Another person's location means they are being exposed to both, but they're only being monitored for one.

The Institute for Energy and Environmental Research, IEER, was issued some papers in 1997 from the Department of Energy. And it states from the start of the nuclear age until 1989, radiation doses from radioactive materials inhaled or ingested by workers were not calculated or included in worker dose records. This is revealed in a background paper to the IEER.

Last, DOE has admitted the following problems: External exposure data are often incomplete or unreliable; raw dose data and electronic versions of the data which are often used by researchers or studies do not always agree. Third, in some cases worker dose records contain entries stating the dose was zero, regardless of what the actual dosimeter readings were. I myself

have this experience. Thank you.

DR. ZIEMER: Thank you, Phillip, for those comments. If you would just wait a moment, let me ask if any of the Board members have questions for Phillip.

(No responses)

DR. ZIEMER: It appears that they don't, and your comments will be on the record.

It's now time for our lunch break. We actually are a little behind schedule, but again we -- well, no, we're on schedule. I have just 12:00 o'clock, so we will recess until 1:30.

(Whereupon, a luncheon recess was taken.)

BOARD DISCUSSION/WORKING SESSION

DR. ZIEMER: Before we resume deliberations, I'd like to remind all present, if you have not already registered on the attendance roster -- Board members and public and staff alike -- this is registration for today. Yeah, I think we keep that roster for both days, so remind you Board members, even if you registered yesterday, you should sign that roster today. Isn't that correct, Cori? Is Cori here? Is that correct? Yes, that is correct. So all present should be sure to sign the roster for today. That's everybody here present. Yeah, use

the same name as you used yesterday.

The second point, again, if there are members of the public who have comments to make during the comment period later this afternoon, we would appreciate having you sign up sometime in advance so we have some idea of how many wish to speak.

Now we are going to return to the discussions that we were having concerning the conflict of interest issues, and I want to make sure that -- I'm sorry?

DR. DEHART: (Inaudible)

DR. ZIEMER: Not yet, Roy, just -- I want to make sure Dick Toohey is on deck if we have questions --

DR. TOOHEY: Right here.

DR. ZIEMER: Dick is here. Okay, thank you. And I actually don't remember exactly where we were except that we were discussing matters -- concerns -- we had been talking about the issue of -- that Roy raised on bullet five, I think it was, and that would have been where we were at the time that we terminated that deliberation. So we can begin there or with any other comments Board members wish to make. So Roy, you're next.

DR. DEHART: It appeared that there was an interpretation that I was making a proposal, when in fact I was asking a question, and I feel that question was answered.

DR. ZIEMER: Thank you. Gen?

DR. ROESSLER: And I think Dr. Toohey's comment pointed out to me very vividly what the disadvantages would be of going to that, and I don't wish to pursue it any further.

DR. ZIEMER: Other comments? Tony, you have a comment?

DR. ANDRADE: Not a comment. I'd actually like to propose a motion, and that is that we leave the wording in the plan as is, and I think that should -- well, actually that should comprise one motion in its entirety, and I can come back to another statement about a letter later.

DR. ZIEMER: Before I ask for a second to the motion, it occurs to the Chair that without a motion, nothing changes. So is a motion actually needed to not do anything? Unless you would prefer, Tony, to have the Board go on record in a more formal way on that issue, and I'm certainly not objecting to having a motion. I'm just pointing out that a motion is not needed to leave things as they

are.

DR. ANDRADE: Absolutely. I understand, and perhaps I should have attached the other piece, and that is that I would like to move to have this Board recommend to NIOSH that a short form, a short letter explaining potential -- or the fact -- well, a short letter should be developed that would have three pieces; one that addresses the individual that will be dong the dose reconstruction, the supervisor -- identifying the supervisor of the person that will be doing the dose reconstruction and also identifying the fact that the entire dose reconstruction will be again reviewed by NIOSH staff. That's one piece.

Second piece would be to leave the form statements essentially in there regarding projects. And the third piece, which is very important, is a paragraph stating that this -- that these people who will be doing the dose reconstruction have been reviewed by the NIOSH representative, NIOSH point of contact for that particular case, and that in this manner they have been vetted and, to the best of everybody's knowledge, has no conflict of interest. So that was the third and a longer portion of the motion.

DR. ZIEMER: Okay. This is a three-part motion, and before I ask for a second I'm going to allow that motion to dangle in the air for a moment 'cause the Chair is aware of another motion that one member wishes to make and I would like -- and I don't know the content of it except to -- I want to ask Jim -- who has, during the lunch period, drafted something -- to what extent what you have drafted overlaps or is equivalent or is similar to what has been proposed. I'm looking for consolidation of things, if possible.

DR. MELIUS: Yeah. I think it overlaps, especially with the one change I just made where it didn't match up.

DR. ZIEMER: In fact, it's identical.

DR. MELIUS: In fact, it's almost -- in fact, I -- and I think it captures some of this in the wording and why don't I just state that and see if we --

DR. ANDRADE: Great.

DR. ZIEMER: The other motion has not yet been seconded. This is just as a point of information, parliamentary-wise. Point of information. We're going to learn about Jim's thoughts. This is not part of the discussion.

DR. MELIUS: It's a POI, point of information. What I was thinking about -- my thoughts are that the Board recommends NIOSH make available to each claimant information about the contract personnel doing their dose reconstruction and the primary reviewer of that dose reconstruction. This information should include a brief summary of the educational and professional qualifications of those individuals and their previous DOE/contractor employment, as well as their expert witness participation. Those come off of what's on that form. This should be accompanied by a letter from NIOSH outlining the procedures for assigning the dose reconstruction personnel, and the procedure, should the claimant be concerned about the assignment of the dose reconstructionist and/or primary reviewer.

The area where this -- my thoughts differ, 'cause it's an additional thought that we really hadn't discussed too much, is NIOSH should also make available on its web site and otherwise the -- and in other ways the background information and previous work history of all contract dose reconstruction and reviewer personnel.

DR. ZIEMER: Thank you for that information.

And now the Chair will make a decision, which can be challenged, and that is that everything up to this last point is in essence contained in Tony's motion, and in fact it could be taken as -- do you agree that that's basically the same motion?

DR. ANDRADE: I do agree.

DR. ZIEMER: And so what I'm going to rule is -- or ask you to hold the last part for -- and have that be a separate motion. So now --

DR. NETON: I'd just -- excuse me --

DR. ZIEMER: We're not discussing the motion yet. Is this a point of information?

DR. NETON: Point of clarification.

DR. ZIEMER: Thank you. Okay.

DR. NETON: Dr. Melius indicated that the letter would be issued by NIOSH. Is that the intent or could the letter by issued by the contractor, as well? At the point when we turn over the dose reconstruction to the contractor, it was our intent that ORAU would actually generate that letter. I just wanted --

DR. ZIEMER: I think the intent is --

DR. MELIUS: The intent is -- yeah.

DR. NETON: Okay. Thank you.

DR. ZIEMER: It's the letter.

DR. MELIUS: Yeah.

DR. ZIEMER: Now let me ask for a second to the Andrade motion which is --

DR. MELIUS: Why don't I second it and that --

DR. ZIEMER: And you second it. And it's -- I'm unsure now of the exact wording, and probably Tony is unsure of the exact wording, or do you have something written down?

DR. ANDRADE: No, I didn't have anything written down, but I think Dr. Melius --

DR. ZIEMER: The recorder has the wording --

DR. ANDRADE: Right.

DR. ZIEMER: -- and let me ask -- and there really are three points, so the Chair now asks whether the assembly wishes to vote on this motion as a whole. Anyone can ask that it be divided into pieces. That's -- and we can -- you may be comfortable with two of the three pieces or something like that and maybe we should -- is there anyone that wishes to divide the motion? Is there a --

MR. OWENS: Dr. Ziemer, I have a comment. If I understood Tony initially, his motion was to -- for the Board to make a motion in support of the

language that is already included here. Was that not part of the original motion?

UNIDENTIFIED: No.

UNIDENTIFIED: Well, it was (inaudible) --

MR. OWENS: But I mean -- but -- but that was a -- but was that not a motion that you made initially?

DR. ANDRADE: It was.

MR. OWENS: Okay.

DR. ZIEMER: But that was never seconded and --

MR. ELLIOTT: We've agreed that it was not necessary.

MR. OWENS: Okay. My understanding was that that was included in the follow-up motion that he made. That was my understanding.

DR. ZIEMER: Is that the case?

DR. ANDRADE: No, because I was going to make two -- Leon, no, because I had intended to make two separate motions, one to leave the language as is. However, I was reminded that by taking no action, we need no motion. So therefore it followed that the second motion that I made really only was in regards to the information that was to be provided to the claimant at the beginning of the

dose reconstruction process.

DR. ZIEMER: Again, let me ask, is there anyone that wishes the motion be divided? It appears that no one does, so we're discussing the full motion, all points. Who has discussion? Comments? Is there anyone that wishes to hear what the motion is? I certainly hope not. I think we --

DR. MELIUS: It varies.

DR. ZIEMER: We basically have two versions of it, but I think we've agreed that it's the same motion. Now if -- did you detect any differences there?

DR. MELIUS: No, once I -- the only reason I wrote it down was I was afraid someone would ask me to repeat it.

DR. ZIEMER: Leon has a question.

MR. OWENS: Dr. Ziemer, prior to a vote, I would like for the entire motion to be read in its entirety, or as far as what we are going to vote on.

DR. ZIEMER: Actually there are two versions of it. One is what Tony presented; one is what Jim presented, which I interpret as being basically the same motion. Do you defer to this wording or would you like --

DR. ANDRADE: No, I would like to defer to

Dr. Melius' wording, given that --

DR. ZIEMER: As the official motion.

DR. ANDRADE: As the official motion.

DR. ZIEMER: Thank you. Then if you would -- if you'll read that.

DR. MELIUS: Okay. The Board recommends that NIOSH make available to each claimant information about the person -- contract personnel doing their dose reconstruction and the primary reviewer of that dose reconstruction. This information should include a brief summary of their educational background -- excuse me, their educational and professional qualifications and their previous DOE/contractor employment, as well as their expert witness participation. These should -- this information should be accompanied by a letter from NIOSH or from the contractor outlining the procedures for assigning the dose reconstructionist and the procedures, should the claimant be concerned about that assignment.

DR. ZIEMER: One more point of clarification, then I'll get your comment, Wanda. Jim, this is a recommendation, as I understand it, to the staff. This is not a recommendation to the Secretary of Health and Human Services. Is that --

DR. MELIUS: Correct.

DR. ZIEMER: -- correct? Wanda.

MS. MUNN: A friendly amendment. I would like to add the word "brief" early on when you start talking about qualifications.

DR. MELIUS: It's already there. I may have missed it. It's -- for the -- information should include a brief summary of.

DR. ZIEMER: Thank you. Other comments?

(No responses)

DR. ZIEMER: Are you ready to vote on this recommendation? Okay, all in favor of the recommendation, say aye.

(Affirmative responses)

DR. ZIEMER: Any opposed, say no.

(No negative responses)

DR. ZIEMER: Any abstentions?

(No responses)

DR. ZIEMER: Carried. Thank you. Jim, it would be appropriate now if you wanted to raise the other issue.

DR. MELIUS: Yeah. Let me start general and --

DR. ZIEMER: Not issue, but the other comment.

DR. MELIUS: Comment. Is it would be my preference that NIOSH also make similar information available on all -- about all of the people involved -- all the contract personnel involved in conducting or reviewing dose reconstructions on its web site, as well as otherwise available to the -- to the claimants. Now whether that should also include this ORAU's web site, I'm not exactly sure how you're setting up your information, but just saying that all this -- the information -- this similar information just should be made generally available, including on the web site.

DR. ZIEMER: Are you making this as a motion or is this a trial balloon?

DR. MELIUS: I put out for discussion -- this is a trial balloon for discussion.

DR. ZIEMER: Just an idea and you want some reaction.

DR. MELIUS: Yeah.

DR. ZIEMER: How do members of the Board feel? Richard?

MR. ESPINOSA: I agree with what Dr. Melius is saying and I would like to make that into a motion.

DR. ZIEMER: Okay. So you so move his

words.

MR. ESPINOSA: Uh-huh.

DR. ZIEMER: Is there a second?

DR. DEHART: I second.

DR. ZIEMER: And seconded. Now this is a formal motion open for discussion. Again, this would be a recommendation to the staff. Wanda?

MS. MUNN: I guess my only real question here -- when we address issues of this sort, supposedly open this sunshine disinfectant -- is to question in my own mind, and hopefully in your minds, as well, whether this is one of those times when we're making things available but it isn't going to make any real difference to anyone. I guess the real -- the real question remains in my mind is whether anyone who has strong suspicions about the validity of what's being performed is going to be persuaded otherwise by this information or not. And it may be a non-question. I'm not challenging whether we should do this. It's just my -- my instinct is that we probably ought to do this, but I don't really think it'll make any difference.

DR. ZIEMER: That may really be a rhetorical question and something for us to think about.

I want to ask a question, and now I'll

direct this -- and maybe legal counsel could answer. Would a contractor or one of these 70 or 90 -- I don't know if you call them contractors, but these folks who are sort of on board to help, would they have the right, if they so choose, to say I don't want my name and resume out on the internet? Or would that be made a requirement of their participation? I'm just -- are we in a position to say unilaterally people's information will be on the internet?

MS. MUNN: To me, this is very much like requiring an insurance company to give me the information about the individuals who have performed the actuarial data that determines my premium. As I said, I'm not speaking in opposition here, I just really question whether this is a valid thing for us to be doing and whether it's necessary or whether it's even appropriate.

DR. ZIEMER: Well, I may have made the mistake of asking a legal question, so while they're pow-wowing here, Robert, do you have a comment?

MR. PRESLEY: Yes. My comment is I think it's great. I'd like to see it done on the web and not sent to each individual.

UNIDENTIFIED: Correct, yeah.

MR. PRESLEY: If you have 90 people minimum and so many supervisors, and we have over 15,000 claimants, can you imagine what the postage and paper's going to be for that?

DR. ZIEMER: And the proposal is not to distribute but to make available on the web.

DR. MELIUS: So now everyone has web access, but if they don't and they want this information, they could --

DR. ZIEMER: They can request it.

DR. MELIUS: Can I also say, before we get a long legal opinion here, that I think we're providing a general sense of what to do. I think there may be some constraints on it and -- I mean that's something NIOSH can work --

DR. ZIEMER: We're not mandating if there's a legal issue.

DR. MELIUS: Yeah, that NIOSH wants -- has to work it out with their contractor, that's fine.

DR. ZIEMER: Other comments?

DR. ANDRADE: Let's see, first of all I guess I'd like to explore the possibility if we do go forward with putting people's names on the web as to whether it would be -- or perhaps legal will give us some advice here in a second, but perhaps it

would be best to limit the amount of contact information to perhaps a professional address, no phone numbers -- nobody wants to be called.

DR. MELIUS: Yeah -- no, that --

DR. ZIEMER: Not suggesting phone numbers and Social Security numbers and --

DR. ANDRADE: Exactly. And I wanted to follow up on the statement that Larry made yesterday that -- by all means, it is your prerogative, duty, responsibility to assign the dose reconstructionist to a case. I don't think it would be a bad thing to have this information on who's out there doing these sorts of things because if you have it clearly stated somewhere -- okay? -- somewhere or this is absolutely made clear to the public that they cannot use this list to go shopping for their favorite person, that you will be doing the assignments, then I think it would be completely harmless to have this information available.

MR. ELLIOTT: I think -- well, first of all, I think we're still trying to get an answer to your question. We've got a two-part answer coming forward, I hope, on that.

Let me just make a clarification. Right now the way we are set up to work with ORAU -- the ORAU

team, we expect them to make the assignment of the dose reconstructionist and the reviewer, the primary reviewer, and we will provide oversight of that process and make sure that we are satisfied that they're tending to the conflict of interest plan as it's presented and described, and all the -- any subsequent processes or procedural controls that we identify post -- you know, this -- today's meeting need to be put into place. We reserve the right to say we don't think that assignment is the right assignment and we want to see you reassign. We also will reserve the right to listen to the claimant and say we're hearing what the claimant says and we want you to make another assignment. And I have no problem with us putting information on the web site, ORAU's web site. We've just got to tend to what's stipulated in the contract and what we need to do as far as controlling for the Privacy Act aspect of this. And that's what's going on behind me right now. They're talking that through.

DR. MELIUS: Can I make one other --

DR. ZIEMER: Jim, please.

DR. MELIUS: I think when we were talking about this and we were talking about NIOSH, we were sort of talking about the broad NIOSH, that it's

NIOSH and the contractor as one, and we're not trying to get into a procedural issue of who exactly does what or where it is, on who's web site and stuff like that, and so forth. And I also think that we're trying to say this as a practical matter. And I guess I could see a scenario where of that pool of 70 great health physicists that ORAU has hidden away out there that nobody else knows about, that -- you know, if there's a person that's unlikely to be assigned, but he's sort of a backup and -- or she is that might use, you know -- that that doesn't -- you know, that person wouldn't necessarily be part of it. Would be some people that are actively involved in the program and I think you have to develop appropriate criteria for that, as well as the type of information that you'd make available on those people.

DR. ZIEMER: Then again, Jim had clarified that the sense of his motion was that if there's some legal barrier in a certain case that somebody had some objection, we're not mandating it in that sense. It's sort of the sense of the Board that if this motion passes that the information generally should be made available, to the extent legally possible, on the web site. So we don't need to

determine what that is today. Gen has a -- did you want to speak -- Toohey or...

DR. TOOHEY: Okay. Just a few general comments. Having all this open and posted on the web site was what we proposed, what we put in the proposal, and it just says with -- if NIOSH concurs.

DR. ZIEMER: You're speaking in favor of the motion then.

DR. TOOHEY: We're prepared to do that. And their -- I think our general take on it, and with our partners, is if somebody doesn't want to do dose reconstructions under these conditions, then they don't have to do dose reconstructions under these conditions and that's the end of it.

MR. ELLIOTT: And could you clarify, is there 90 or is there 70 or --

DR. TOOHEY: Good question. I don't know. I'm trying to recall, what we submitted in the proposal under the total listing of personnel qualifications was 75 plus or minus five names, I believe. Since the time we submitted the proposal we've identified some other people, obviously, but their names were not in there. So 90 right now has -- it's a little better than a wag, but it does have a confidence interval on it comparable to some of

the risk coefficients.

DR. ZIEMER: Okay, thank you.

DR. TOOHEY: And let me comment on another -- just one thing on that. We expect, and it was part of the contract and the proposal, that number to wax and wane as the demand comes in, so we would expect a lot more people working during the first year or so when we're clearing the backlog than would represent a more steady state condition.

MR. ELLIOTT: Well, while you're there, could you speak to another concern that I feel might be out there, that folks have this opinion or understanding in their mind that ORAU is an M&O* contractor or has some M&O responsibility for DOE. Could you react to that for the record?

DR. TOOHEY: Yes, we are not an M&O contractor. In fact, someone mentioned yesterday we were a major DOE contractor, and I suppose that depends on what the name of major is, but I think the total ORISE, Oak Ridge Institute for Science and Education, budget falls off the rounding error in DOE's Oak Ridge operations office. The ORISE contract, which is not an M&O contract, is a collection of somewhat long-standing programs, mostly for -- in the areas of science, education and

emergency management for DOE. Total number of ORISE employees is on the order of 500, about 150 of whom are post-stocks*. There's only about 300 core employees compared with a total of 15,000 or so contractor employees in the Oak Ridge reservation. So it's actually a very small operation, one that does come to that. And I think there's always a lot of confusion, even in town, you know, what's the difference between ORAU and ORISE? Well, ORAU is to ORISE as University of California is to Los Alamos, University of Chicago is to Argonne, et cetera, et cetera, et cetera. It is a contractor operating this entity. ORISE is not a laboratory. It is not an FFRDC or any of these other criteria that you associate with the normal M&O or M&I contract.

Last time Oak Ridge ops bid the ORAU contract, I think they called it an O&M. Okay? Operations and management, but specifically to make the point legally that it is not an M&O contract. And although we supply post-stock researchers for Oak Ridge National Lab, we are in no way involved in the M&O part of ORNL and -- and in fact, this is all in the ORAU corporate disclosure statement, which is also part of the COI plan.

DR. ZIEMER: Thank you. I think Dr.

Roessler has a question.

DR. ROESSLER: I'm in favor of the motion but I did want to point out one thing. With the web site that I'm in charge of where we provide answers to questions -- it's an ask-the-expert feature -- we list only the name of the expert, sometimes their affiliation. People get ahold of them, even if you don't list contact points. They are able to reach them, and so I think you just have to be prepared for that. Some people are very good at getting the contact information.

DR. ZIEMER: Any further discussion on the motion that's before us?

(No responses)

DR. ZIEMER: Are you ready to vote? Appears that we're ready to vote. All in favor of the motion, say aye.

(Affirmative responses)

DR. ZIEMER: All opposed, no.

(No negative responses)

DR. ZIEMER: Abstentions?

(No responses)

DR. ZIEMER: Motion carries. Thank you. Now I think we may be ready to hear from the working group on dose reconstruction. Mark?

MR. GRIFFON: Sure.

DR. ZIEMER: You want a break first?

MR. GRIFFON: You want to take a break?

DR. ZIEMER: No. No, we'll proceed.

MR. GRIFFON: Okay. There were two handouts that should have gone around to everyone, and I believe they're available in the back of the room, also. The one document isn't titled. At the top of it it says Project Identification and Purpose. The other one says Attachment A, Technical Evaluation Criteria. The first -- the thicker document with Project Identification and Purpose is what the working group's been working on -- from yesterday we talked about a scope of work for the independent expert review, and this was sort of formulated into -- potentially into an RFP here.

Just before this session I did talk to Jim Neton and there may be other potential ways to -- to put this into the public domain for potential bids. One thing that Jim Neton brought up was possible -- possibly releasing this on a task order basis, so we can talk about that a little bit.

I think part of it -- and you'll see as we go through this, part of it is that we do have some concerns, especially on some items, of whether we

can sufficiently define the scope of each task that a bidder can sufficiently bid. And we do want to expedite this process, so we're trying to balance those two things of knowing what we want the expert -- or the -- this review contractor to do versus a timeliness of getting this out there and getting them on board to begin to do their work.

So either way, I think if this were to be -- at least as a task order contract -- a task order basis, I think we would still have these four primary tasks which we're going to discuss, so I think we should go through those and discuss those. They'll be relevant at some point, either way this is released.

If you look on the first page, the -- B.1 through B.4 really are the four that I presented yesterday, the four primary tasks. I review-- B.1 is review methods/procedures used by NIOSH and NIOSH contractor in conducting the individual dose reconstructions and the SEC petitions.

B.2, review of a percentage of individual dose reconstructions completed by NIOSH OCAS.

B.3, review a selection of the site profiles established by NIOSH OCAS for the sites covered under the EEOICPA program.

And B.4, provide technical support to the Advisory Board for review of the SEC petition determinations.

So those are the four main tasks as presented yesterday. This entire document, by the way, may need a technical edit for things just sort of like we just discussed, NIOSH instead of contractor, things like that we certainly have not cleaned up at this point, but...

The next page, C.1 through C.4 gives an overview of the tasks, and section E gives a more robust description of those four tasks. I could probably move -- I think the main -- I thing we could go to section E and talk about the scope there. I don't know if people have even had a chance to look through this, so if you want more time to read through this and --

DR. ZIEMER: Well, you can lead us through it, I think.

MR. GRIFFON: Okay. In section E now, I'm just going to move on to section E. Section C is just a brief synopsis of sort of what's in section E. Section E, the scope of work. E.1 is the review of the dose reconstruction methods/procedures. And you'll see the 1 through 6 items in that paragraph,

the first one, review the internal and external radiation dose reconstruction technical basis documents, and then these go on down to a fair amount of detail on different types of procedures or -- and/or methods that we would want reviewed. And most of these, especially 2 through 6, I believe, came out of the ORAU contract -- the NIOSH-ORAU contract language. NIOSH tasked ORAU to do -- to specifically look at many of these issues, so that's where many of these came from. I don't know if I need to read through those or -- I'll -- we can stop for any point for questions, or how do we want to work this?

DR. ZIEMER: Let's take questions as you go. Let me back you up just a moment 'cause I have a point of clarification on the project objectives, which are -- it's in section C, and I think your intent is -- aligns with what I'm thinking about, but this says the contractor will determine whether the methodologies are consistent. The contractor shall determine whether the assumptions -- the burden is on the Board to make that determination. The contractor, in my view, assists us in making that determination, so I would hope that it would be very clear that this is -- the contractor is not

making the decision. You understand the difference? I think it's what you intend --

MR. GRIFFON: Yeah, I think you might find similar things throughout --

DR. ZIEMER: Right, so I'm suggesting that wherever we've said something like that, it is in the sense that the contractor will assist the Board --

MR. GRIFFON: Right.

DR. ZIEMER: -- in making that determination because it is our responsibility to make the --

MR. GRIFFON: Agreed, agreed. Okay, so maybe we can just stop at E.1 -- it'd be easier for me if we stopped at E.1 and if people wanted to discuss -- I think part of -- part of the discussion on maybe possibly releasing this as a -- on a task order basis was just this, that the challenge in E.1, for instance, was -- you know, we thought it made a lot of sense for an initial review of procedures/methods. However, we're kind of operating in the dark because we don't know exactly what the proced-- what procedures and methods are out there 'cause things are just getting started. So we were a little afraid that we could not well define this, you know, scope for some of these

tasks. But given the -- I'll just open it up if anybody has comments on that.

MR. ELLIOTT: Your comment troubled me a little bit because you said there -- we don't know what methods are being used, but we do know what -- we have the implementation guides on the web site. Those are -- those are the rule on dose reconstruction, and the two implementation guides serve as the starting point for the methodology. And as we proceed -- and I'm sure Jim's going to -- he's already up, maybe he's going to speak to this, as well, but any -- as we learn and as the contractor -- as the ORAU team does dose reconstructions and learns, with a specific dose reconstruction, a new process or new way of doing it or something that wasn't accounted for in the implementation guide, we'll have a technical bulletin. And those technical bulletins will become also part of the process and the methodology and incorporated into the administrative record for that particular dose reconstruction.

MR. GRIFFON: Okay, but not -- not to -- I mean there -- there's some things, not to use words I've heard before, but case by case basis. I think 2 through 6, there are certain things there where

your staff has already thought about certain ground rules or certain assumptions or cert-- you know, certain techniques they will use, so you know, I understand that there may be revisions or technical bulletins or, you know, amendments or modifications to, you know -- but I didn't know if 2 -- I didn't know if 1 through 6 here captured the -- 100 percent of all procedures currently being used or being, you know...

DR. NETON: I just have a couple of comments. I think Larry captured the first portion pretty well. I think these things are evolving and that -- that does speak to what -- why this may end up -- be better issued as a task order contract, and I thought maybe for the benefit of the Board I might explain how that process would work so that you would better understand what we're talking about.

In a task order arrangement, what we would issue would be a request for someone to bid on a -- essentially a statement of qualifica-- we would provide a statement of qualifications of types of labor categories that the Board is interested in procuring. So for example, one could say the Board needs in the following year the services of a senior dosimetrist for X thousand man hours, a junior

health physicist blah, blah, blah, and so those labor categories would essentially be on the hook during that contract period and available to provide services to the Board. Once that contract -- and those -- that contract -- or that would be evaluated based on the qualifications of the personnel that were proposed to meet that task order contract, as well as the pricing for those labor categories. So it's sort of a trade-off between the qualifications and the pricing. Those would be the evaluation criteria.

Once that contract is in place, then each of these individual pieces that the working group has assembled could be issued, either piecemeal or all at once, to the contractor and you could say here is the following statement of work that I want you to address with those labor resources that you proposed to use. So I think it's a very good way, since this is not very well fleshed out and changing, to accomplish this.

MR. GRIFFON: And it sounded very good. One thing that I mentioned to Jim before we reconvened here was -- one angle that we're not getting in there, which -- or I don't know if we can or cannot, it's an open -- I guess it's a question to consider

is the conflict of interest angle, which -- you know.

DR. NETON: Yeah, I think we could cover it. I think somehow in there with the qualifications and plan that the task order contractors should have a plan in place to cover those contingencies, that sort of thing.

DR. ZIEMER: Any other questions then on E.1. We're still on E.1, I think. Right?

MR. GRIFFON: Right.

DR. ZIEMER: And aside from the details on the wording, you're really asking have you covered the things.

MR. GRIFFON: Right.

DR. ZIEMER: We ourselves don't yet know what it means to review their procedures. That is, we have to develop a procedure for reviewing. I mean we've talked about this in the past. Do we have some kind of a checklist that says they have followed their guides, have they used the right information, whatever it is. But we have to have ourselves a procedure that's -- that we say yes, this is how we're going to do the review.

MR. GRIFFON: Right, right, and we had some discussion on that. We just -- you know, we -- I

guess it was sort of part of the challenge of to find the scope, too, was the depth or -- the depth of review --

DR. ZIEMER: Right.

MR. GRIFFON: -- could change the magnitude of this project drastically, so --

DR. ZIEMER: And in fact that might even evolve as you gain experience.

MR. GRIFFON: Right. Larry looks like he's waiting to make a comment on that.

MR. ELLIOTT: The comment I've been thinking about is one I mentioned to you earlier. I'm struggling in my own mind to understand how E.1 and I guess E -- what is the other one here I'm thinking about -- E.3 are not covered in E.2. I mean as you have your technical consultant review an individual dose reconstruction, you would have them review the methodology used at that particular point in time for that dose reconstruction, as well as whatever the site profile was -- you know, as it existed at that time. So wouldn't that -- wouldn't E.1 and E.3 be covered in the process of doing E.2?

MR. GRIFFON: Well, just -- I mean my notion in this, and other group members can certainly chime in, but my notion was that E.1 is sort of -- is an

initial task, and part of the reasoning there is that if you just incorporated it into E.2, you may come -- you may come across a situation where your auditor, you know, has drastically different opinions on 20 cases and it's because they have a drastically different view of a certain -- you know, a certain technique that was used. And to the extent that those can be flushed out early on, I thought it would behoove the whole process that we have one up-front review and then, you know, the auditor can say to ORAU yes, we agree that this meets the requirements in 82 CFR, you know, or -- you know, and then you could have possibly even a hitter* in the process where that ORAU may make revisions or NIOSH may make revisions on that.

MR. ELLIOTT: Well, that is helpful. So E.1, as you see it, as the working group has discussed it and sees it, is initial one-time review effort to establish for the Board are the methodologies that we've put in place correct. I mean of course down the road five, six, ten years, the Board might say hey, we need another look --

MR. GRIFFON: Right.

MR. ELLIOTT: -- at the methodology being used since it's evolved over time.

MR. GRIFFON: Right.

MR. ELLIOTT: And I understand that. That helps.

MR. GRIFFON: That's the way -- that's the way I see it. And I guess if in the other -- in E.2, as you did individual cases, then you may find out that certain bulletins have come out to -- or, you know, procedure three may be 3.10 by then, so you would -- would certainly include in your individual case review the relevant procedure at that time. But that one clean slate sort of up front review of the procedures and methods so that everyone is on the same sheet of music. That was the intention.

MR. ELLIOTT: Understood. Is E.3 under that same context?

MR. GRIFFON: E.3 is under a similar -- the only -- the only con-- the only problem I had, again, with the scope here for E.3 -- I guess we're skipping E.2 for the second thing. E.3 talks about the site profile review and (inaudible). I guess the only problem with scope there was that these profiles are evolving, certainly. So in the first year we weren't even sure how many would be available for review.

I think that the way I envisioned this, again, was that there would be certain triggers or flags that the working group and the Board picked up on that would trigger a site profile review, and that would kick into E.3. And those -- for example, as I see Jim's tagged off*. One of those triggers could be that you have -- you have a facility where you have done many of the interviews and you find out that there is large discrepancy with what people are reporting in the interviews versus what's in the case file that NIOSH has available, and you say well, wait a second, we need to -- to use Jim Neton's word, we need to pull the thread on this a little bit and make sure that this site profile data is compl-- is sufficiently complete to do a reasonable estimate for the doses.

MR. ELLIOTT: That's very helpful. I appreciate that and in that context these would be better served under a task order contract for technical consultation. That'd just be my --

MR. GRIFFON: I don't disagree -- yeah, I don't disagree with that. I -- that -- in the hallway five minutes before this meeting was the first time I heard of a task order contract, so that's...

DR. ZIEMER: There is a sense in which the site profile does get imbedded in the individual dose reconstructions because, for example, even in the film badge or TLD data, you need to know something about the frequency of change and the calibration, the sensitivities and so on, and much of that comes out of the site profile. So the very process of doing E.2 may raise issues about the adequacy and completeness of the site profile anyway. So --

MR. GRIFFON: And that could be a trigger for a more in-depth review. I guess E.3 was --

DR. ZIEMER: One way or another, you end up reviewing the site profile, either as an outcome of E.2 or as a separate exercise in case.

MR. GRIFFON: Right. And I guess the way we were envisioning E.3 also was that it was not just a percentage of the site -- you know, the site profiles that were there. The selection criteria may not be a random statistical approach, you know. We may have -- and it's controlled by the working group, and I thought that we could better define this in the protocol that I presented at the last meeting. You know, refine our case selection process a little better, but also refine our site

profile review -- refine that selection process a little better as we move forward here.

DR. ZIEMER: Jim?

DR. MELIUS: Yeah. Just a -- I'm going to jump back to E.1, so hopefully this isn't confusing -- too confusing. But my initial reaction -- you know, I have the same question that you did, Larry, and the -- whoever this contractor or contractors are, they can't do dose -- review dose reconstructions unless they've reviewed the guidelines and understand them and so forth, so it will be part and parcel of doing that, and they could be combined, in that sense.

However, in another sense, in terms of as these evolve or as an issue comes up in terms of doing dose reconstruction for which you decide that you need some sort of guidance or guidelines or some refinement there, that in order for the Board to review that area, particularly in some of these very specific technical areas, that we would also be drawing on this contractor for doing that. So in the full -- initially it's really part and parcel of E.2, eventually there may be separate tasks there.

DR. ANDRADE: Very much related to most of the previous comments, however, I see them -- I see

these related in a different way. I'd say that one must do E.2, at least at the basic level, to determine whether the dose reconstruction methods and procedures are adequate. Okay?

And I also -- at least in my mind -- attach site profiles and how they are used as part of the methodology which exists in E.1. So I'd say except for doing a blind, raw -- what did we call it this morning?

MR. ELLIOTT: Raw case file data.

DR. ANDRADE: Case file -- reconstruction, I think these three are very intimately interwoven, right, and that we could probably come up with a scope of work that really is only one piece.

I fully support E.4, which is, I think, something that we're going to -- probably will need some technical assistance to grapple with, but I don't think we've gotten there yet.

In any case, that's the way I feel about it, that you do have to do basic dose reconstruction to actually review the procedures and the adequacy of those.

MR. GRIFFON: I can just respond to that one part. I -- I agree with that. I'm not saying that you would just review E.1 and never look at a case,

but those -- E.1 and E.2 -- I sort of saw E.1 being and the top of the priorities and E.2 maybe starting in parallel with that, but I -- E.1 being an early task in this -- in this group's mission, you know. So I don't disagree with that.

DR. ZIEMER: Comments on I guess E.1, 2 or 3?

MR. GRIFFON: Well, E.2, for those who haven't been following along, E.2 was the --

DR. MELIUS: What are we supposed to be doing?

MR. GRIFFON: A lot of those details are, you know, what we passed out in the protocol last time.

DR. ANDRADE: Well --

DR. ZIEMER: Tony.

DR. ANDRADE: Okay. The following comment. Mark, I -- I agree with you that I think these tasks can be done in parallel and should be done in parallel, and I believe that it will evolve. I really and truly believe, personally, that this will evolve into an exercise in which we do basic dose reconstruction to come up with comments, findings, et cetera regarding the items, the procedures, the items in E.1.

I really believe that if we start with E.1 as a separate piece, what we're going to be doing is educating a contractor -- I'll slice that -- to the degree that we have been educated about the process, and perhaps even further so to the degree that the OCAS health physicists are in performing or in going through this process, and I'd say this is -- to me, this scope of what would be involved in carrying out 1 by itself is a tremendous scope. It's a huge scope to try and go back and understand everything that goes into all the health physics, all of the assumptions, all of the claimant-friendly decisions or methods in which decisions are made, all of those things. I think that comprises just a huge work scope. And I think rather than trying to educate a contractor for us to do that sort of thing, it would be perhaps more efficient if we were to, in your words, choose some cases wisely and then use those cases for them to independently go out and make determinations on the adequacy of the methodologies that are being used.

MR. GRIFFON: Okay. I don't -- in my mind I'm trying to see how the scope would differ if they were looking at those same procedures and methods while they were doing cases, as opposed to on

parallel tracks. I mean I don't disa-- it could potentially be a fairly large scope -- scope. I don't disagree with that. But --

DR. ZIEMER: Part of this depends on what we mean by review. It's one thing to say go back and review what they're doing. Okay, I've gone through it and I understand it. That's one thing.

It's a completely different thing to take a step back behind that and say now go back to all the source documents and to the Japanese data and -- and review all the assumptions that go into this, so we need to be careful --

MR. GRIFFON: We did also reference the rule, and we've, as a Board, even though it was before I was on the Board, we did review that rule. So to the extent that that applies, you know, they don't go -- the intent was not to go further back than that, and that --

DR. ZIEMER: Well, those are --

MR. GRIFFON: That sets certain parameters for --

DR. ZIEMER: Right, that's -- those are givens.

MR. GRIFFON: Right, so that certainly came up in our working group as a discussion. That is

certainly not the intent.

I guess the other way to get at this -- what does review mean, Jim and I were talking -- and I hope I get this right -- is that on a task order contract we could put a not-to-exceed type of provision in there. So I think -- you know, defining review a little better, but also saying not to exceed -- I think the contractor's going to get a pretty clear message on what level of review is expected.

DR. ZIEMER: Does the task order then specify deliverable --

DR. NETON: Yes.

DR. ZIEMER: -- the nature of the deliverable?

DR. NETON: Definitely. It would essentially be these little scopes of work with deliverables and an estimate of the amount of resources required to perform that task. I think the contractor actually would estimate the -- is that right, Larry? I'm getting that mixed up. The task order itself -- the contractor would come back with an estimate of the amount of resources -- the hours required to perform that task.

MR. ELLIOTT: That's right. Yeah, that's

right. The task order itself will set a need for technical consultation, and so you define in that what -- what skill levels you're seeking to support that consultation effort. Then once that's -- once that's awarded, then you come forward with these task orders, and the task order then has to be reacted to from the contractor as to how many hours and which skill levels they think are best applied to do that. And then there's a negotiation that goes on about that.

DR. ZIEMER: Jim?

DR. MELIUS: Yeah, I was just going to get to that sort of similar point, that I think it's the task that'll bring these two issues together. It's how you define those tasks, the deliverables for the tasks and so forth that -- and I think we probably need to spend some time thinking how we want to do that so that review doesn't become, you know, too all-encompassing. At the same time, part of it does maybe come to focus on specific cases and there's a way of -- of accomplishing this. I just found it helpful to separate out the scope this way in sort of thinking about what we wanted, what kind of help or assistance we wanted as part of this review of the Board, do that. I think it tends to all come

together much more when we start talking about the tasks, and it should, at that point.

MR. GRIFFON: I think the other -- just to respond to Tony's point on the -- on E.3, the other reason for separating out E.3, if you will, for the site profiles reviews was, you know -- again, this -- the trigger to be determined, the selection to be determined by the work group and the Board, not the contractor, but it was to allow for a task which would involve a more in-depth review of the site profiles as opposed to -- I know E.2 does touch on that, and E.2 -- in doing E.2, you expect that you might find some sites where you were -- where we -- where it triggers the need for that more in-depth task, and it was to allow for that more in-depth task and specifically -- and this is something that we haven't -- we've been grappling with -- it is specifically -- you know, the level of that. We -- I think we agreed more in-depth, and what does more in-depth mean? I have a phrase in there I think which some people will -- you know, we need reaction to, which is -- which could involve DOE -- may involve site critical experts, and the site expert language was taken out of the contracts with ORAU where it's pointed out that ORAU will interview

teams of people, including former workers, health physicists, supervisors, et cetera at the various sites in constructing the site profiles, so we thought that this independent contractor review, if they were doing E.3, they might want access to that team, as well, and access to DOE. And I know that access to DOE is certainly something that is of concern. I mean right now it seems like access for -- you know, the MOU is not even in place for NIOSH to get access, so -- anyway, I just want to point out the reason for separating it out was to allow for more in-depth and we certainly don't envision a large percentage of sites being done in that E.3, but...

DR. ZIEMER: Now let me raise a question, because I want to make sure that we're looking at all of this in a sense as a kind of audit. The primary contractor has the job for NIOSH to determine the quality of the site profiles. I mean they're developing them -- they're developing site profiles -- huh?

MR. GRIFFON: Are you saying the ORAU team?

DR. ZIEMER: Right, they're developing site profiles on behalf of NIOSH, and in a sense, also determining whether they're adequate to do the

thing. They're doing a lot of that.

MR. GRIFFON: Right, they're doing the work.

DR. ZIEMER: It seems to me that in an audit you say -- you go back and you say to the contractor, how did you get this information? Where did it come from? What's the quality of it? Are there holes in it? I want to make sure that we're not just doing the same thing over to see if we get the same answer. We're -- the audit -- if I can think of it as an audit, is to look at how they developed the site profile. Is there a whole lot of information they forgot about going after? You see what I'm asking? And I think that is the intent, but I want to make sure the words here aren't telling our contractor that we want you to go back and do a site profile.

MR. GRIFFON: Well, the -- the second paragraph -- site profile, second paragraph, second line tried to get at that point --

DR. ZIEMER: Yeah.

MR. GRIFFON: -- which talks about the review should focus on whether --

DR. ZIEMER: Right.

MR. GRIFFON: -- whether NIOSH/the contractor -- if everybody found that line -- yeah.

DR. ZIEMER: But is that the working group's understanding of what they're asking for, is what --

MR. GRIFFON: That's the understanding, yes. But that -- that may not -- you know, that still may require access to DOE sites --

DR. ZIEMER: Yeah.

MR. GRIFFON: -- to these interview groups.

DR. ZIEMER: And you won't know that till you get into the process, of course.

MR. GRIFFON: Right.

DR. ZIEMER: Right. Other comments? Okay, Roy.

DR. DEHART: When we were discussing this in the working group, what helped me to understand exactly how these were breaking out was that E.1 and E.3 were confidence builders for us. They let us know that the contractor was following all the rules, had procedures in place to do things. When we came to E.2, we broke down the audit into three levels, if you remember. A basic audit, which doesn't get into depth on either 1 or 3, and then we go to a more advanced review, which does give a chance to do that and it may obviously be in -- at sites that were not reviewed in 3, for example, because they could be coming from different places.

And then finally we go to the third, the blind audit, where we're asking our contractor to take the same basic data that was made available by NIOSH, or that the contractor acquired, and -- without seeing how they went about calculating it, we do that. But we needed to be comfortable with 1 and 3 in order to proceed with 2.

DR. ZIEMER: Okay. Wanda?

MS. MUNN: I'm very pleased to see you bring up the word "audit" and to have Roy repeating that. It appears to me that in many places here where the word "review" has been used, it would clarify what my understanding of what this group will be doing, to use the word -- or the term "audit" more frequently with -- than "review".

DR. ZIEMER: Other comments? You want to continue, Mark, on -- where are we now?

MR. GRIFFON: Yeah, I guess I can mention E.4. It's not very well fleshed out, but it's there. Again, this is SEC petitions, technical support. And we -- really we just thought that this is probably going to be a future need for this Board and at least -- but if we did this as a task order, I don't think --

DR. ZIEMER: Then it could be tasked --

MR. GRIFFON: Right.

DR. ZIEMER: -- at some appropriate point.

MR. GRIFFON: Right. And then moving on to section F, it talks about personnel requirements. These personnel requirements are actually very closely aligned, I believe, with the RFP that was put out for the ORAU contract. And then the next part of F, part B, is a little bit short in length at this point.

DR. ZIEMER: It would be a similar --

MR. GRIFFON: Right, we have similar issues. I do -- there's two points. One -- we had talked about three items, and we couldn't really get consensus in the five minutes we had left this morning before the meeting, so we thought we'd bring these items to the full Board and discuss, rather than try to lock in language. One was the notion of -- that the bidder should produce a conflict of interest plan, which I don't -- I think we have pretty good agreement on that.

But the second one was this notion that we discussed before lunch, which was that the -- I don't have the precise language here, but the notion that they never worked on behalf of the DOE in any litigation around Workers Comp or radiation-related

claims. And I think -- it seems like we had some agreement that that language was okay for the ORAU contract. We think it would -- I mean I thought it would make sense in this one. I don't know. We can discuss that.

Let me just go -- the third item was the idea of including some sort of criteria that would restrict key personnel who have -- have in the last five years, which was sort of arbitrary benchmark selected by me, worked with the DOE, DOE contractor, AWE or ORAU. And the brief discussion we had with our working group -- and I also recognize this -- is that, you know, this sort of criteria could really limit our pool of expertise, and also the balance we were trying to strike in this is that, you know, we do want the scientific expertise and we realize that a lot of the people that are going to be best suited to do some of these difficult dose assessments have had experience at these facilities. That's where they learned this stuff. So we had to -- we want to balance the scientific expertise with a conflict of interest. Ideally, we'd have someone who had, you know, great scientific expertise and no conflicts in the last five years, but are we -- is that too restrictive -- is that restricting our pool of

experts too much. That was sort of the discussion we had, so...

I don't think we came to agreement on anything on those, except for the possible -- the notion that the bidder should provide a conflict of interest plan. And you know, at a minimum, we thought that was -- that should be part of the provision. Beyond that, the parts -- those are the three primary things.

DR. ZIEMER: Okay, let's open this --

MR. GRIFFON: So previous -- previous employment with DOE or worked as a expert witness on behalf of the DOE in a Workers Comp or radiation litigation case.

DR. ZIEMER: Wanda, is there --

MR. GRIFFON: And that was ever, not in the last five years.

DR. ZIEMER: Wanda, you have a comment?

MS. MUNN: At the risk of being repetitive, because I brought this up before, I see this as going after the same expert pool that we bled over in trying to identify what we now have with the ORAU contract. And since I've not seen anything in any of this material that stipulates that people we're working with must be U.S. citizens, I can't help but

again raise the issue of is it not reasonable for us to consider the possibility of perhaps Canadian health physicists who would be familiar with many of the same types of procedures? Is it not reasonable for us to include them in our potential pool?

MR. GRIFFON: Larry probably wants to respond to that. We discussed this on our last conference call and I'll ask Larry to maybe...

MR. ELLIOTT: Go ahead.

MR. GRIFFON: Well, I guess they're -- from the procurement standpoint, there would be many more hurdles, as I understand it, to hiring non-U.S. citizens, so it's certainly an option, as I understand it, but -- go ahead.

MR. ELLIOTT: Let me elaborate. It is an option. It will require, as Mark says, more procurement hurdles to clear because in the Federal acquisitions regulation there's this clause that requires us in government procurements to contract within the United States as much as possible to get the best value for the government and use U.S. national support in that way. But it can be done, it's just going to be more difficult to put in place.

If I -- if I could comment here, it seems to

me that -- I want to make sure I'm clear on this. Is 2 and 3 part of what you see of 1? I mean a conflict of interest plan is needed, and should it cover 2 and 3, or is 2 and 3 a requirement?

MR. GRIFFON: No, 2 and 3 were meant to be requirements, as I was -- as I was proposing them. But we didn't have consensus in our working group, so this is --

MR. ELLIOTT: This is --

MR. GRIFFON: -- an open discussion.

MR. ELLIOTT: I think 2 and 3 as a requirement would be better placed in the evaluation plan, and I'm not so sure that you can even place number 3 in the evaluation plan. You can't restrict -- you can't restrict potential proposers in this regard, but you can couch the language such that if they have this kind of affiliation within the last five years, that diminishes their competitive advantage or competitive ability to succeed in getting an award.

MR. GRIFFON: As I had -- originally had drafted this, the language in this section B was almost duplicated in the evaluation plan, which is also now stricken, but -- but we still have the concern and the concern is that, you know, this

would -- potential bidders might look at this and see the evaluation criteria and say, you know, this -- I'm going to get knocked out, why should I even bother, you know. So that was --

MR. ELLIOTT: You certainly, in the scope of work for the task order contract for technical consultation, require a conflict of interest plan as part of the proposal. And then in your evaluation plan you can address this -- this 2 and 3 criteria, and you can assign points to those.

MR. GRIFFON: Right.

MR. ELLIOTT: And the way you couch that language reveals what you're interested in, what's the best value for the government in this regard and what you're seeking in that. You can handle it that way, but --

MR. GRIFFON: Can I ask why, from a -- I mean I assume this is a legal issue. Why can't 2 and 3 be in the proposal itself? I don't disagree with it, including it in the evaluation plan. I'm just asking.

MR. ELLIOTT: I think it can be there if you say a conflict of interest plan must be provided with the proposal that addresses the following items. You can go at it that way, you see? But you

can't have like you've got to have all three of these or you can't have nothing. You need to have a conflict -- the conflict of interest plan is the umbrella, and you provide instruction and direction to the proposers on what you hope to see in that conflict of interest plan. And then you use your evaluation tool --

MR. GRIFFON: But you're saying to do it the other way would violate procurement rules --

MR. ELLIOTT: I'm not so sure. I need to check on that, but I think it's better placed in the evaluation plan, those two elements, and then couched in the scope of work as you -- a proposer needs to submit a conflict of interest plan that would encompass X, XY and Z, ZZ, those type of things.

DR. MELIUS: Can I comment? I think the concern would be that it -- by putting it as an absolute requirement, this issue of who's really going to be available with the appropriate technical expertise and the wording of it becomes much more difficult if you're disqualifying people because of that. I think by doing the evaluation I think it gives us some flexibility in terms of wording and evaluating that and of -- I mean that's -- in a fair

and appropriate manner, but there's some flexibility to look at different criteria within that -- within that element, as well as to weight that against other elements, including technical expertise. And I think it would -- certainly would do less to dissuade people -- appropriate and qualified people from --

MR. GRIFFON: Yeah, I don't -- I don't disagree with that --

DR. MELIUS: -- applying.

MR. GRIFFON: -- general logic, I just didn't know if there were some specific rules we were violating potentially --

UNIDENTIFIED: (Inaudible)

MR. GRIFFON: -- 'cause the other -- the other side of this that I'm cognizant of is -- is -- we will have a review of this, and there is an evaluation plan and to some extent the working group and the Board have input and control over the review panel. That may not be the case. We may have representation on a review panel, but as I understand it right now, as we've discussed it, this will be a NIOSH review panel, so just in terms of -- that was part of the reasoning for including an up-front criteria instead of rather just in this

evaluation plan where then the review panel would go behind closed doors and make their considerations on weighting these things. That was part of the logic behind that, that NIOSH is hiring their own auditor -- the perception possibly that NIOSH is hiring their own auditor and they've got the panel that's reviewing these plans and they can --

DR. MELIUS: Yeah, but just to clari-- my understanding would be the weighting of the factors would -- in the evaluation plan is done up front, and then the panel applies that, that weight you give --

MR. GRIFFON: And those are still -- and those are (inaudible), I agree --

DR. MELIUS: Yeah, I think there's -- it's not --

MR. ELLIOTT: And the technical evaluation panel can't deviate from that plan once it's established in the proposal, in the RFP, so they have to abide by whatever you -- you know, that final -- is set to be by you, the Board.

DR. ZIEMER: Other comments before -- are you going to go on to the attachment then or --

MR. GRIFFON: Well, let me just ask then -- then for -- since -- since we do want to move ahead

with this, if we were -- I mean I think we -- in principle, anyway, I'm agreeable to that solution. The question I would have is those two -- you know, the con-- the evaluation plan, should it include criteria -- I think we all, before lunch, it was sort of agreed on the involved in litigation on behalf of the Department of Energy clause. The second clause is more restrictive. Do people agree that there should be a provision in the evaluation plan that says if the -- if key personnel have worked -- and I'm abbreviating, but if key personnel have worked with DOE, DOE contractor, AWE, ORAU in the last five years, you know, that -- that would be a -- one of the weighting criteria that would work against them? Is that agreeable?

DR. ZIEMER: The wording that was in the other document I think we agreed was acceptable, did we not?

MR. GRIFFON: They didn't have any such provision, I don't believe.

DR. ZIEMER: Are you talking about -- are you talking about litigation or worked for?

MR. GRIFFON: Worked for.

DR. ZIEMER: Worked for.

MR. GRIFFON: Right. That's a more

restrictive provision and I'm asking if that's -- we'll certainly circulate the language that we come up with, but is that a reasonable criteria to include within the evaluation plan?

DR. ZIEMER: One of the ways you do this -- as I understand the evaluation plan, you can score them. Suppose that everybody that comes in is -- it's been four years, not five, and you don't have -- are you going to throw all the proposals out or do you say if it's -- if it's been -- if it's been more than five years, they'll score higher. But if there aren't any of those animals, we'll go to the four-year one and maybe they're better off than the threes and the twos. Wanda?

MS. MUNN: That gives you the rationale to propose Canadian personnel to do that.

DR. ZIEMER: There are no qualified people available.

MR. GRIFFON: Yeah, and I think that -- yes, I agree with you there, so okay.

DR. ZIEMER: So it doesn't become -- it becomes a kind of guide or sliding scale where you can score it, and those who --

MR. GRIFFON: Depending on how recently -- what kind of work --

DR. ZIEMER: Yeah.

DR. NETON: I would --

MR. GRIFFON: This is all -- we're still going to look at attachment A, actually, so --

DR. NETON: I would propose that there's a balancing criteria, though, for the expertise, as well, so they have to offset each other. I mean a conflict of interest balanced by a set of work experience criteria that are really great, I mean you have to score both of those and strike a balance.

DR. ZIEMER: Right, there would be other criteria that get scored. Roy had a comment.

DR. DEHART: That bullet we were talking about before lunch was not exclusionary. It simply was information that was to go into a database. Let's not get confused thinking that those people would not have been hired.

DR. MELIUS: Well, I can't remember the exact bullet, but -- to determine whether -- some were informational, some were -- would be criteria that were considered in terms of assignment. They were allowed to be part of the contract, but not be assigned to certain -- certain cases within that contract.

Back to sort of Mark's question, I think if the, you know, working group then came up with a set of balanced, you know -- and evaluation plan that incorporates these and really you have to sit down and sort of work out what the scoring should be and so forth, I think we could probably come to pretty easy agreement on that, based on our discussions here so far.

MR. GRIFFON: Yeah, I agree with that. Okay? And I don't think there's much to -- the big discussion for the technical evaluation criteria would have -- would have been these same items, which is section F, which is left out right now.

DR. ZIEMER: So the real issue then that comes before us at this point is that, given that this is roughly what you -- what we need -- I say roughly because there may be some polishing to do -- how does it get implemented in terms of the process? Is that correct? And it's not clear to me at this point if the working group now was proposing this as a draft version of a procurement document --

MR. GRIFFON: Well, I don't -- I think this is more of a discussion document at this point --

DR. ZIEMER: Yeah.

MR. GRIFFON: -- because I think we -- we

have to reconsider -- if it's a task order proposal then it wouldn't include this scope information and we just would outline technical qualifications, et cetera, so...

MR. ELLIOTT: I agree with Mark. I think this has been a discussion document. I don't think it's in the shape and form ready for us to put before a procurement officer to put out an RFP. I would think that the working group probably needs to have another meeting or two, you know, with Jim's -- Jim Neton's involvement and perhaps Martha DiMuzio, as you've had her engaged before, to discuss procurement options and process.

I want to make sure that we -- on the record it's noted as an advisory caution that all of this is preliminary. And for the audience's benefit and for those who read the transcripts, this is in fact preliminary and it's not -- it's pre-decisional and no one should start preparing a proposal against this.

Additionally, I think we need to make sure that you understand that the business aspect of this proposal, the budget and the independent government cost estimate that has to be created that goes along with this, still has yet to be discussed by the

Board and it's -- because this was a discussion document, it's premature to do that and we couldn't do that today or yesterday because we had not announced it in the *Federal Register* notice for this meeting. You need to understand it'll take us 60 days, at a minimum, to put such in place for you to have a executive session meeting of that sort. So you've got that much time to pull this together, as well as the business part of the plan. But we would need to know perhaps today, if that's your pleasure, that you want -- the full Board wants to have an executive session.

MR. GRIFFON: And that executive session, can that be via conference call or what -- what...

MR. ELLIOTT: No, it needs to be face-to-face, because we cannot verify by telephone that there -- that the participation is limited to the Board.

DR. ZIEMER: And if we use that 60-day as a starting point and use today's date, that means, at the earliest, December 16. That is theoretically.

MR. GRIFFON: Let me ask just one more thing for the working group's benefit. If we're going to go down this path of discussing the business aspects of this, including person hours, et cetera, for the

task order, can we do that via conference call with the working group?

MR. ELLIOTT: I think you have already done that, and so by precedent, yes --

MR. GRIFFON: Thank you for saying yes.

MR. ELLIOTT: -- you can. You have done that. We're concerned about that, though, and if you prefer to have a face-to-face, we will accommodate that. But we want to look at how the phone -- such a phone conversation meeting is set up with you all. We're going to look into that and see if there's a way we can do that so that we verify that only the parties on the line are those that need to be on the line.

DR. ZIEMER: You're talking about working group then.

MR. ELLIOTT: Working group, yeah.

MR. GRIFFON: 'Cause my -- my --

MR. ELLIOTT: The working group meeting has not been a public meeting. It's -- working groups don't have to be announced in the *Federal Register*. They don't have to be a public venue, and that's the way this has been going up to this point. It's all been work in progress and pre-decisional, and so you could continue along that line.

MR. GRIFFON: As long as we -- you know, I think my feeling is that, you know, the 60-day limit, I think we need to make that decision now is my --

DR. ZIEMER: The decision that needs to be made is whether the Board wishes to have an executive session at the appropriate time, which in essence would probably be our next meeting. And what I was getting at is the earliest we could do that would be December 16th. Now I know from talking -- and incidentally, if you had some November dates blocked off on your calendar for this Board, you may recall that those were back-up dates in case we couldn't meet today, so those you can -- you can delete those from your calendars.

I've talked to some of the Board members and I didn't detect a great deal of enthusiasm about meeting between December 16th and New Year's, which suggests that we're into January before the full Board could meet. We will, in fact, after our break, talk about a specific meeting date. And the issue then would be do you wish, during that meeting, to have an executive session to address the budgetary aspects of such a proposal. If we want to do that, it would be useful for the Board to go on

record to request NIOSH to go through whatever steps are necessary, including the *Federal Register* notice and other requirements, 'cause there are some other requirements within the government. If you're going to have an executive session, the topic has to be know, the attendees have to be known, it does have to have a court reporter, so there are some very specific requirements that have to be set up if we are to have an executive session.

Roy and then Jim.

DR. DEHART: My question would be is it necessary for the Board to participate in the business plan of this proposal? In other words, do we need to participate in the budget and those kinds of issues?

DR. ZIEMER: Let me -- let me partially answer that is that the working group was set up to bring recommendations to this Board. They are not authorized to act on behalf of the Board unilaterally. In the normal course of things, whether or not this included the budget, whatever recommendation comes, the protocol is for the working group to make a recommendation to the Board. At that point we have to take action. And insofar as there is -- there are these issues, including the

budgetary issues, an executive session would be called for. Jim?

DR. MELIUS: What if -- Roy asked my question, so I'll elaborate as another possibility. What if the Board approved what's been presented to us today, you know, with whatever, you know, changes and so forth --

MR. ELLIOTT: Conceptually.

DR. MELIUS: -- conceptually and so forth --

MR. ELLIOTT: (Inaudible) scope of work and the evaluation plan?

DR. MELIUS: Correct. And then, you know, authorize the working group to work with NIOSH to, you know, implement this.

DR. ZIEMER: You're saying to authorize the working group to reach the final decision.

DR. MELIUS: Yeah, that we've done a -- you know, done the major part of the work.

MR. GRIFFON: I think he's saying he doesn't want to meet.

DR. MELIUS: Well, I'm --

DR. ZIEMER: We're going to meet anyway.

DR. MELIUS: Well, the question is would this expedite the -- the process? I think -- I think a lot of us would like to see this in place

sooner rather than later and I think it would make the whole process work -- work better, and if it's not necessary to delay it an extra 30 days or whatever it's going to take, given the gains -- I mean given the amount that would be gained from having executive session. I just don't see necessarily a lot of gain from an executive session that has to be done in person due to -- to do this.

MR. ELLIOTT: You certainly could do it that way. You could task the working group with the responsibility of coming up with the business portion of the plan, of the proposal. We at NIOSH don't want to do that. But yet at -- I'm required to manage the budget and the resources, so I'm very much interested in this piece. You certainly could approve the two pieces that you've looked at today, once the working group has put those back together and fleshed them out better and taken into consideration the thoughts and the comments that you've offered today, and that would obviate the need for executive session at your next meeting. And if you felt you needed to have a teleconference to approve the working group's scope of work and evaluation plan before the next face-to-face Board meeting, then you could do that. You could have

that, and we could attend to this business plan just between staff and the working group.

DR. ZIEMER: But your comment was NIOSH does not want to do that? Or what was that?

MR. ELLIOTT: NIOSH -- we could come up with the business part of this plan and develop the independent government instrument, but I don't think you want us doing that. We don't want to do that. We have to monitor it and I'm responsible for managing all of this, but I don't want the perception out there that NIOSH is hiring the contractor, is controlling the amount of funds that are going to be placed before this effort. That's the problem. So I think it's important that you all work through that.

DR. MELIUS: But can I just -- it is a task order contract.

MR. ELLIOTT: Yes.

DR. MELIUS: And so the tasks are going to change over time and would be subject to review by the Board over time so that it's not as if we're making it -- recommendation or a decision -- the Board is not making a recommendation or decision at this point as to what would be the financial scope of this overall --

MR. ELLIOTT: Yes, you do. You really do. You have -- there has to be a business part of this plan that gives an independent government estimate of the funds needed to conduct the scope of work. And under task order contract, you're able -- we're able then to put more funds into it if we exceed the funds that were awarded. Okay? So if you don't expend all of the funds that were awarded in the first year, they carry over into the second year of the contract. If you expend all of the funds that were awarded in the first year, we put more funds back -- back into the contract. But we have to have this -- what's called an independent government estimate that is used to -- for me to sign the funding document that says funds are committed for this procurement. Now that's not releasable to any RFP. The proposers don't know what the independent government estimate is. They don't have that level of knowledge, but it has to be put in place before we can effect this procurement.

The other thing that Jim's kindly reminded me of is for this Board's sense of the time line here, once the scope of work has been approved and the procurement process is complete to the point we issue the RFP, request for proposals, and that would

appear in *Business Daily*, that will take 45 days as a minimum, 15 days for the announcement and 30 days for proposals to be submitted, so you need to factor that into your time line for your considerations. So whenever the scope of -- the draft RFP that includes all these different elements is prepared, there's that 45 days, plus there's a processing time that we never can predict at NIOSH through procurement. We've worked -- as Mark knows already with the procurement folks, they know this is coming down the pipeline, they know this is urgent. It has the Office of the Secretary's sense of urgency about it so I'm sure that it's going to get expedited. But there's probably 30 days for the procurement office to do whatever magic they have to do to turn this thing into an RFP, and then 45 days, at a minimum, if that's what you want. If you wanted more time to try to capture more proposers, you would just need to add that.

DR. ZIEMER: I'm going to have us recess briefly. You can cogitate on this information and then we'll be prepared immediately after that, so we'll take a 15-minute break here.

(Whereupon, a recess was taken.)

DR. ZIEMER: We're trying to ascertain what

legal issues there might be involved with authorizing the working group to act on behalf of the full Board. It's not -- it's not completely clear that they can do that. We don't know the answer to that legally at this point, I don't think.

There is also some possible perception issues on taking that route that it could look to a casual observer that this was a method whereby the Board decided to circumvent the process of taking our action through the regular meeting. Even though it would be an executive session, but it still would be an announced meeting with an announced topic and so on. It could look like an end run to the FACA process if we weren't cognizant of that. So there are some concerns that at least have been expressed about that approach. It's not clear whether that's something we should do.

In any event, it is clear that we want to move ahead. And it seems to me -- and I think other Board members would concur -- that it's obvious the working group needs to proceed -- and even meet in person, if they need to, but by phone if that's better -- to put the -- these documents in final form. It's not quite clear how much time that would take, but even -- even if it were -- if it's

determined that they could legally have the authority to act on our behalf on the business plan, it's not clear that that would necessarily speed things up very much, if you look at all the different parts of this issue in terms of what's required in procurement and so on.

I have the feeling that we would be well-served to plan on an executive session at our next meeting, and in the meantime have the working group move ahead on preparing the documents, get them ready. We could have a Board -- we could have a Board conference call, without the business plan, as soon as that's ready to bless the scope and so on. And we would have a little better feel for where we were timetable-wise. But it would seem to me that it might be appropriate to plan, because if we're going to have an executive session, we need to start that process right now. And it would almost be better to start that process and then decide we don't need it than to not do it and then find out that we do need it.

So let me ask if anyone would object to us proceeding in that way. The work -- it's sort of a tandem process. Wanda, I am going to let you speak, but --

MS. MUNN: No, no.

DR. ZIEMER: -- it's sort of a tandem process where we would proceed under the assumption that at some point this Board has to bless the final business plan. That would require an executive session. But in the meantime the working group would proceed to work on the final development of the scope and so on, and at some point between now and our next meeting, we would probably need to have a conference call meeting -- again, publicly announced and available for the public -- to review and make a final blessing of the scope. We're assuming that you might be able to get that all done sometime before the year's end.

So let me ask for reaction to that. This is just sort of the sense of what I got in talking to various people during break. Mark, if you would.

MR. GRIFFON: I mean I guess I was going to ask that we -- you know, whether the Board would agree that if we don't need that executive session, if we can do it prior to that, is the Board comfortable with having the working group do the business side of that?

DR. ZIEMER: If it can be done legally and if there aren't any ramifications. And I might also

add that if -- it seems to me, and I have no way of knowing one way or the other, it might be possible to do it legally and you would still have the perception issues that it's legal but it's an end run on the process.

MR. GRIFFON: Perception issues from --

DR. ZIEMER: The public.

MR. GRIFFON: Even though these executive meetings are not open to the public.

DR. MELIUS: Can I --

DR. ZIEMER: The executive meetings are not open to the public, but they are announced in terms of the content of the meeting. There is an official record kept. This is not true of the working group. So they are closed to the public, but the knowledge of what is going on, that -- this is a -- this is a very specific topic that's being addressed, who is there doing it, when it's occurring, and the record is kept.

MR. GRIFFON: And the record, yeah, that's --

DR. ZIEMER: And that meets the FACA requirement, even though it's a closed session. Okay. Jim, Wanda -- Wanda, you had a comment first or -- no. Yes?

MS. MUNN: I don't believe there's any question that this Board has a job to do that has both time constraints, ethical restraints and legal restraints that none of us are pleased with. We all would like this to be able to be done sooner, quicker, easier with the smallest possible amount of effort by everyone involved. But I don't see any way that that's going to happen. I am prepared to move, when the Chair would like such a motion, that we ask the task group to move forward with completion of the scope of work that's before us and with developing the budgetary items that are necessary to complete the recommendations for an RFP, that we immediately make notice of the need for an administrative session at our next meeting, and that we plan to spend a significant amount of time at that meeting -- my guess would be, given the amount of deliberation we usually have to go through, I can't imagine that we would do that in less than a day -- at which time the working group would bring to us their draft of the proposed business plan that we would then be constrained to act upon.

DR. ZIEMER: And Jim, do you have a comment?

DR. MELIUS: Yeah, and I'd like to get some

clarification from Larry and whoever else he needs to ask, to the extent that he can clarify it, 'cause -- on some of these issues. If I'm correct in my understanding that the business plan we're talking about is for a task order contract is simply some estimate of the number of hours of work involved in that?

MR. ELLIOTT: It's skill levels and hours associated with those skill levels. There's different rates for different skills.

DR. MELIUS: Okay. Number two, I'm confused from some of the prior statements, but is there any reason that NIOSH is unable to do that under procurement rules, or is your concern only the perception if NIOSH makes those determinations?

MR. ELLIOTT: Yes, it is -- we could do this. My technical staff could do this, come up with the business plan. But a part of the role we have of managing and controlling perception of conflict of interest includes OCAS staff, as well. And so that's the issue -- perception here that we're driving this in the direction, perhaps. And I've tried to be very cooperative and collaborative and having staff be the same with the working group, trying to do our level best to work through the

procurement issues to get the Board involved in various ways, the Board members integrated in this process so that you have ownership as much as possible in the RFP, even to the point of -- as we learned yesterday, the resolution that a Board member could serve on the technical review panel gives ownership in the selection of the final award.

DR. MELIUS: Yeah. The other -- I guess this is a comment to the Board is that the other perception that we have to be concerned about is that if this contract is inordinately delayed, to remember that there will be a lot of claimants out there who may have concerns about their dose reconstructions, that the Board will not be in position to review those dose reconstructions because there -- we will not have a contract in place for doing that and that depending on how quickly ORAU gears up and so forth and so on -- I'm not quite sure what the schedule will be, but we're talking about that where a 30-day delay or a 60-day delay would mean that there would be, you know, literally hundreds of people that will have gotten their final dose reconstructions and that we will not have a process in place or not be able to respond to concerns about the review of those. So I

think that perception or potential problem has to be weighed against the perception of NIOSH controlling or -- you know, over-controlling or whatever you want to call it, being biased in their -- in their involvement in different parts of this process. And I think it's very hard for us to make some of these judgments because we also know that, despite all the best efforts on the part of NIOSH, that this proposal could get buried down in contracting for six months and all sort of other things can delay it that are beyond everyone's control. And we -- also having problems really figuring out what this schedule will be that -- and maybe the -- one of the ways to think about this is to work backwards from what's -- when will our next meeting be. Realistically, what can -- how close will we be to getting -- having a scope of work and these other parts figured out. I mean if this -- having an executive session is going to mean a difference of a week or two weeks or something, that's very different than if we're talking about a delay of 90 days or something like that. And I think if we work backwards, maybe we can come up with sort of a practical solution to this rather than trying to figure out all the legal things and balance some of

this out.

DR. ZIEMER: Other comments? Roy.

DR. DEHART: In listening to Wanda's comments, following it through up to the last comment that she made, I was in essentially full agreement. What I would like to see happen is not have the Board review a draft when we next meet, but have the Board, having already reviewed a draft, that it would be forward to them with the completion of the working group, and make comments by teleconference. And if necessary, a second teleconference to finalize that, certainly before the holidays, so that when we come to our next meeting, that has been done and all that needs to be done then is the -- the final business plan.

DR. ZIEMER: Roy, that is what I had proposed. It's only the business plan that requires the executive session, and certainly a full Board review before the end of the year is conceivable, in my mind, if the working group is able to finish their work.

I sort of had in my mind that we would probably, in any event, want to meet in January. But we do need to look at some dates here shortly, but -- and maybe you would want to do that first,

following -- before we have a formal motion following Jim's idea to sort of see when we're going to meet next and then what implications does that have on this particular process.

And let me add one thing, Jim, and you made a comment -- I hope that there's not a perception that our review of the system will hold up the awarding of -- we do not review decisions before they are finalized. In fact, the audit process is like a bank audit. It's always after the fact. The rules do not require completed dose reconstructions to be approved by this Board before awards are made. I hope you weren't implying --

DR. MELIUS: I was not implying that. I just -- and that's why I guess I was using some of the numbers there. I think there -- people with concerns about the process or about their own dose -- because there will be so many in process, both completed and in process, that people will -- that the overall process will be better served if people know that there's a --

DR. ZIEMER: Right --

DR. MELIUS: -- review --

DR. ZIEMER: -- and it's that that we're concerned about, that if there is a glitch, we don't

want the process to be going on for a long time before it's corrected.

DR. MELIUS: A glitch or just that -- I think it'll -- that our review will be very supportive of the overall effort on the part of NIOSH and the credibility of this effort.

MR. GRIFFON: Just as another option, and before -- before I said it, I'll say I might not even vote for this option, but as another option, could NIOSH -- just -- just in the -- 'cause this is 60 days potentially, or maybe not 60 days but some amount of time that we're adding onto the front end just to have an executive session. If we have some agreement on the broad tasks, the four tasks ordered -- the four tasks in the task order, my understanding is that a task order is the -- is the way these would be written, they can be expanded in the future, so there could be a possibility that NIOSH could come up with the initial business plan for the four tasks. And like I said, I'm not sure I'd want to vote on this myself, but NIOSH could come up with the initial one just to get it out there with the -- if the Board -- if there was an agreement on this Board that the -- we could have future executive sessions to discuss the expansion

or -- if need be, the expansion of the -- of that business plan. I don't know if that's an option.

DR. ZIEMER: But again, I think the cautions -- Larry's already told us that NIOSH can come up with a business plan, and the issue really boils down to is that really what you want to do, particularly in terms of perceptions.

MR. GRIFFON: But I guess one way I was thinking that this could avoid the perception problem is that, you know, we would make it very clear as the Board that we can review these business plans in the future and expand them if necessary, depending on --

MR. ELLIOTT: No. There could be no expansion of the business plan. Okay? Nor the scope of work. If you expand the scope of work or you expand -- if you say that oh, hey, you know, we -- within the scope of work, we can add money, once the money that had been allocated originally has been expended and the work remains to be done, you have tasks yet to be done. Okay? Under that scope of work. But you can't expand the scope of work because that's a new RFP, has to be recompeted. In a new RFP, we would require a new business plan. So I'm lost on expansion.

DR. MELIUS: Well, I think expansion refers to expansion of tasks or the amount of funding available for tasks that would fit into the scope of work, and I --

MR. ELLIOTT: As long as the task is encompassed in the scope of work, we're okay. And we can add -- we can add funds as we proceed. It's going to be an open-ended task order, but original amount of funds has to be allocated, and will have to have some criteria that the proposers can develop their proposals against. Okay? And that's where the independent government estimate comes into play.

MR. GRIFFON: You mean -- criteria, you mean more specificity in the task items. Is that --

MR. ELLIOTT: No.

MR. GRIFFON: No.

MR. ELLIOTT: No, the type of skills needed and the hours needed to conduct those skills in a given year. That's what's going to be place out there in the RFP. Okay? The type of skills that are necessary to complete this -- this -- the tasks under this technical consultation. Okay?

DR. ZIEMER: In the sort of parallel path that I described earlier, after the working group completes its recommendations and we do as Roy

described and bless them in a conference meeting, before an RFP is released -- which is the business plan part and the scope of work -- I think there are some internal NIOSH things that have to occur. And let me ask. Are there some steps after -- after -- here's what I'm getting at. Suppose a preliminary business plan was developed by the working group. We have not yet blessed it, but they have developed it. Are there some internal steps before an RFP is issued that have to occur at NIOSH where that part of it could start, awaiting the final blessing of the Board on -- the full Board on the business plan so that when our blessing occurred the RFP can go out right away? Do you see what I'm getting at? An RFP is not going to go out the day after we say -- after the working group says we have a business plan, even if we -- if we could legally and agreed to authorize them to do it, it's not going to go out the next day after that occurs. Right? There's something that happens internally, surely.

MR. ELLIOTT: Yes, there is a lot that happens internally.

DR. ZIEMER: And that in a parallel fashion --

MR. ELLIOTT: And the ans--

DR. ZIEMER: -- in anticipation of Board action.

MR. ELLIOTT: The answer is yes, up to a certain point. And I don't -- I'd have to get with procurement to find out what the point -- what's the drop-dead point here where they could not process the procurement any further without knowing that the Board supports not only the scope of work but the business plan.

DR. ZIEMER: Again looking for some efficiencies in these processes.

MR. ELLIOTT: And I'm sure there's this point, there's this control point where they would not move any further -- move the procurement any further until they understood that the Board had approved the whole -- the whole RFP, whole scope of work, everything.

DR. ZIEMER: Comment, Wanda? Okay. Suspending all that for the moment, can we look at -- can we look at -- it's my sense in terms of -- even though this is mid-October, we know that the staff is going to really be busy in the next few months as the contractor gets up to speed. It's unlikely that any of us want to meet in December.

MR. GRIFFON: Is that ruled out?

DR. ZIEMER: No, I'm -- I don't want to rule it out. I haven't -- I haven't talked to anybody who's very enthusiastic about it.

MR. GRIFFON: I mean --

ADMINISTRATIVE HOUSEKEEPING AND BOARD WORK SCHEDULE

MR. ELLIOTT: If I could, behind your tab under housekeeping, there's a calendar if you don't have a calendar. And I know Cori would like to have this anyway. She'd like to know what your -- we'd like to know what your availability is. This is a housekeeping item. So your availability beyond -- you know, if we're talking January, think about that, as well. You might want to use this calendar and turn it in to her. Okay?

And yes, we are going to be very busy. December is always a bad month for holidays, and if you know anything about the government service at all, those who are fortunate enough to have use or lose leave are forced to use it in that month, December, unless there's very good circumstances of why they cannot, and then they're granted a reprieve from that. They don't lose it. You know, there's things like this that we have to take into consideration.

MR. GRIFFON: So the week of December 16th

to 20th would probably not be a good candidate, huh?

DR. MELIUS: Well, and I think another way of looking at that is that nothing would probably get done between the next -- the next two weeks, anyway, so you know -- till after the 1st, so -- there's lots of meetings usually that week, but not much work after that week.

DR. ZIEMER: Cori?

MS. HOMER: The week of the 18th is out for me. I'll be in the Caribbean.

DR. ZIEMER: Okay. And I don't suppose we're allowed to meet there, either. Right?

Could I ask you to look at January calendars and let's find out -- who has -- who's not available the week of January 1st?

MR. PRESLEY: (Inaudible) the week of the 6th?

DR. ZIEMER: I'm looking at the wrong year.

DR. MELIUS: Are we going forwards or backwards?

DR. ZIEMER: Here we are, yeah. The week of January 6th.

MS. MUNN: I have a minor conflict on the 9th. I could change it.

DR. ZIEMER: On what?

MS. MUNN: On the 9th, but --

DR. ZIEMER: But not serious?

MS. MUNN: No, I could -- you know, I can move --

DR. ZIEMER: Anyone else that week that's particularly bad?

MR. ELLIOTT: Henry's okay that week.

DR. ZIEMER: Week of the 14th?

MR. ELLIOTT: Henry's not available -- that's actually the 13th, isn't it?

DR. ZIEMER: Well, 13th is a Sunday, 13th is --

MR. ELLIOTT: Henry's not available on Tuesday the 14th. He won't be available --

MS. MUNN: No, Monday the 14th.

DR. ZIEMER: Any others that week? How about the week of the 21st?

MR. ELLIOTT: Henry's not available Thursday the 23rd.

DR. ZIEMER: That's Wednesday.

MR. ELLIOTT: I'm sorry?

DR. ZIEMER: You know what, I'm still looking at 2002.

MR. ELLIOTT: 2003.

DR. ZIEMER: Cori, you gave us 2002.

MS. HOMER: No, there should be --

MR. ELLIOTT: And I'm just reminded that January 20th is a Federal holiday.

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

DR. ZIEMER: That'd be a good day to travel on, wouldn't it?

MR. PRESLEY: I'm not going to be available that week.

DR. ZIEMER: You're not available that week at all, Robert? Okay.

MS. MUNN: Why don't we just go back up to the first week? I was the only one who had any --

DR. ZIEMER: I was just trying to get an overview of everything. You want to try for early in January?

MS. MUNN: Yeah.

DR. ZIEMER: First week of January, the week of the 5th?

MR. PRESLEY: Sixth.

DR. ZIEMER: Or 6th. The 6th is Monday. What days, Tuesday/Wednesday?

MR. PRESLEY: That's fine.

MS. MUNN: Depends on how long --

MR. ESPINOSA: Where are we going to be

meeting at? That's...

DR. ZIEMER: We can -- we certainly can meet in Washington. Oak Ridge is a site we talked about meeting. There are other sites like Hanford that are interested in having us visit, keeping in mind that a portion of this is going to be executive session so that makes it less convenient for members of the public, but --

MS. MUNN: D.C. is probably the best bet.

MR. PRESLEY: I'd like to have you come to Oak Ridge in the spring.

MR. ESPINOSA: What about the Pan-Tex area?

DR. ZIEMER: Texas?

MR. ESPINOSA: Yeah.

DR. ZIEMER: Pan-Tex itself is a little hard to get to, but we could go to Texas, San Antonio. Is Pan-Tex the nearest?

MR. ESPINOSA: Amarillo. Amarillo or Lubbock would be --

MR. ELLIOTT: I'm sorry, our recorder cannot capture everybody's conversation at once. I would ask -- including myself.

MR. GRIFFON: Do we want -- I don't know if we want to go to one of the sites where we expect a lot of public participation when we're going to open

up with an executive session for --

DR. ZIEMER: Well, that was the point I was making. It's less --

MR. GRIFFON: You know, I would rather go to those sites at another time when we had a --

DR. ZIEMER: Yeah, when we had a full meeting. You just want to -- shall we go to Washington then?

DR. ROESSLER: How about Cincinnati?

MR. PRESLEY: Cincinnati's fine.

MR. ESPINOSA: Cincinnati's great. I think that's great.

MS. HOMER: Let me know then. Washington can be very difficult to get on short notice.

DR. ZIEMER: Okay.

UNIDENTIFIED: Washington's not a real safe place to be right now, folks.

DR. ZIEMER: You want to go back to Cincinnati?

MS. MUNN: What do you mean Washington's not a --

DR. ZIEMER: Robert was suggesting we come to Oak Ridge in the spring and it's -- if we went to Seattle or somewhere in the Washington area, it would be for the benefit of the Hanford folks.

Again, I think, Mark, your comment is pertinent again. Do we want to go there when the chance to interact is abbreviated.

MR. GRIFFON: Especially Hanford. I mean I'd be concerned about locking off into a six-hour executive session when you have people --

DR. ZIEMER: Robert.

MR. PRESLEY: It looks like the working group's going to be working with Cincinnati pretty close. It might be that we need to go into Cincinnati in January. That way Larry's got all his experts and staff and things like that up there if -- when we meet with this executive group, as an executive group.

DR. ZIEMER: Richard?

MR. ESPINOSA: Is the working group going to meet face-to-face or are we going to meet in conference call? How do you plan on doing that, Mark?

MR. GRIFFON: I don't know that we've resolved that, but for scope and for the evaluation part of it, I'm assuming conference call. To draft budget, I don't know if we have an option of a conference call for that. Yeah. Okay. So conference call would be the preferred method and

most likely.

DR. ZIEMER: Shall we plan on Cincinnati for January?

MR. PRESLEY: That's fine with me.

DR. ZIEMER: It appears to be okay.

MR. ELLIOTT: Was that January 7th and 8th?

DR. ZIEMER: 7 and 8, January 7 and 8 in Cincinnati.

DR. MELIUS: Otherwise known as the big blizzard of 2003.

DR. ZIEMER: Right.

MR. ELLIOTT: I would wonder if it would be the Board's pleasure to consider a secondary date in January --not as an option, not as another -- an option before this one, but as an option for another meeting, a second meeting in that same month to take up perhaps the SEC rule incase we're not ready by the early part of January, and because this 6th and 7th -- or 7th and 8th date is pretty much -- seems to me to be wrapped up trying to get this -- get through this working group and this statement of work. So I'm just throwing that out. I mean we're not sure where we're going to be at at that point in time on the SEC rule.

DR. MELIUS: Can I just make sure I

understand this right, but my sense would be that the executive committee portion of this is a half-day or something. I mean 'cause the scope and most of the work on the contract's done and it's not --

DR. MELIUS: Resolved ahead of time, and that I would -- certainly would like to limit the executive committee as much as we can, simply if we're having -- for public availability and those sort of issues, so if that's a half a day, that still would give us a day and a half or whatever for that. And then I guess my question, Larry, is that -- I don't know if you can answer this; you usually can't, but I have to ask it anyway -- is what is your expectation of the Board's involvement in what's happening with the SEC rule?

MR. ELLIOTT: I'd like Ted to answer that. Obviously I didn't have the answer.

DR. ZIEMER: We haven't heard much from Ted.

MR. KATZ: No, I've been happily quiet. I mean this is all sort of contingent and depends on how things work out, but if we have -- if we come out in January with something that requires -- that opens up public comment again, then as before, we would want the Board's advice, as well. So that's -- that's what would happen. And as to the time

line, that's hard to predict, but the very beginning of January, given what Larry told you about how the Federal departments work in December and so on, it's just pretty -- I think that's really a high risk to make it in the beginning of January for that, if it is to come out in January, so -- I think it'd be good to at least hold open some dates on that possibility later in the month, but...

DR. MELIUS: Or in early February?

MR. KATZ: Or in early February.

DR. MELIUS: What's the -- the comment period would be, if there is a comment period?

MR. KATZ: I mean again, that's all sort of unknown at this point, but I'm assuming if we're going to have a comment period, we're going to try to condense things, make things happen quickly, so -- so that's why it really would be good to have the Board meeting right around the time we'd have something available for the Board.

MR. GRIFFON: Do you know what the minimum --

MR. KATZ: Well, the minimum -- I think the minimum we'd consider -- I mean I think there may be special provisions to do less, but I don't think we'd even consider something less than 30 days for

public comment.

DR. ZIEMER: Larry, are you simply asking that we get some dates set aside and we would decide later whether we would actually need to use them, but get them cleared on people's calendars? Let's see if that's doable.

The week of January 26th, are there any major conflicts the week of January 26th?

MR. OWENS: Dr. Ziemer, that's not -- that's not good for me.

DR. ZIEMER: Not good. That whole week is bad. Okay. How about the first week of February? Any --

DR. ROESSLER: When is the health physics meeting, the mid-year?

DR. TOOHEY: It's the week of the 27th, Gen.

DR. ROESSLER: Of what month?

DR. TOOHEY: January.

DR. ROESSLER: Oh, really?

DR. ZIEMER: Yeah, the health physics -- health physics mid-year is 26th through 29th. It's in San Antonio -- sounds like a good time to meet in San Antonio.

The first week of February, is that bad for anyone?

DR. MELIUS: Monday's bad for me, but otherwise --

DR. ZIEMER: Otherwise?

DR. MELIUS: Yeah.

DR. ZIEMER: Would it be better to meet like on a Wednesday and Thursday? How would Wednesday/Thursday of that week as a set-aside date?

DR. MELIUS: From Tuesday on is fine for me, so...

DR. ZIEMER: Yeah, shall we do that?

MR. ESPINOSA: The first week of February?

DR. ZIEMER: Yeah.

MS. HOMER: What dates?

DR. ZIEMER: It would be 5 and 6 for the meeting dates. Any conflicts there? Is Henry okay on that?

MR. ELLIOTT: Henry's okay on that.

MS. HOMER: Location?

UNIDENTIFIED: Hanford.

DR. ZIEMER: Hanford in February.

DR. MELIUS: I really would like to -- I think we should get out to a site -- a site we haven't been to for that meeting, particularly -- the SEC comments are --

UNIDENTIFIED: You could go to --

MR. ESPINOSA: You can catch direct flights from almost anywhere to the Bay area. I think Lawrence -- near Lawrence Livermore would be ideal, too.

DR. ZIEMER: Or Savannah River area.

MR. ELLIOTT: We have more claims from Hanford, Savannah River, Oak Ridge than we do from Lawrence Livermore/Lawrence Berkeley combined. So I just offer that for your consideration. And certainly I know that around the Savannah River site there have been advisory board meetings of other advisory bodies, the health effects subcommittee and the ACERER has met at Charleston, Savannah, Augusta, Aiken, Hilton Head, so -- which are south at that time of year.

DR. ZIEMER: Well, just as a practical matter for the snowstorm of 2003 or whatever it is, a southern location may be preferable. Wanda, how's -- how's Hanford that time of year?

MS. MUNN: Hanford that time of year can be very nice, as a matter of fact. I warn you again, don't try to fly into Seattle and then think you're going to drive and get to Hanford easily. If you're going to go there, you must fly into Pasco and -- but my rule of thumb is I keep my studded tires on

until the 15th of February, so -- so you're on the cusp. It will be -- it will be sunny, and it will probably be cold, but as long as you're flying into Pasco rather than flying into Seattle, you'll be fine.

MS. HOMER: What about Spokane?

MS. MUNN: You don't want to drive down from Spokane that time of year.

There's a possibility you're not going to get much public from Hanford up there, but you can do it.

DR. ZIEMER: Shall we focus on Savannah River area? Okay, and you can pick out a nearby town that's -- you've got to see what facilities are available.

Okay. So that -- and that's still going to be kind of tentative 'cause it's going to depend on where we are on the rule.

MS. HOMER: When will you know for sure?

DR. ZIEMER: That's what we -- that's what the Board is asking the staff.

MS. HOMER: (Inaudible) and if I have to cancel after the contract is signed, we pay penalties.

DR. ZIEMER: Sure.

MR. ELLIOTT: We're going to know by December. We'll be able to coordinate by December.

DR. ZIEMER: Okay. Thank you.

DR. MELIUS: Let us know.

DR. ZIEMER: Now, working backwards, given that we have a January meeting date, are there any proposals now for handling the dose reconstruction work group's issues, and that is do you want to proceed in a parallel path, what do you wish to do? And instruct the staff to arrange the executive session for the January meeting?

DR. MELIUS: Yeah.

DR. ZIEMER: Can I just take it by consent that that is the sense of the Board, or we don't need a formal vote (inaudible) without objection then, we'll proceed on a parallel process. And that has included with it the idea that if we finalize the scope and so on and if NIOSH is able to start moving through the procurement process internally awaiting the final Board blessing, that they will do that, as well. Is that the understanding?

MR. GRIFFON: Is it also the understanding that we'll have potentially the working -- I mean once the working group completes scope and tech evaluation, we might call for a Board --

DR. ZIEMER: Right, and --

MR. GRIFFON: -- conference call meeting?

DR. ZIEMER: Keep in mind that Cori needs -- how much advance notice do we need for *Federal Register* for a conference call of the Board?

MS. HOMER: Well, I'm supposed to have 30 days, but if there's less time, there's less time.

DR. ZIEMER: But it's not going to be let's -- you know, we're done, let's have a Board call the next day. Cori's got to have a reasonable amount of time to get the notice in the *Federal Register* and get the conference call set up, so... Okay?

MR. GRIFFON: Should we ask for dates on that, considering that you need 30-day notice? Should we ask for dates -- potential dates?

DR. ZIEMER: This is to have a conference call of the full Board to review their recommendations --

MR. ELLIOTT: Scope of work and language --

MR. GRIFFON: Right. And I'm assuming we're looking at dates at least 30 days from now, or 30 days from --

DR. ZIEMER: Yeah, I think we're getting -- we're getting into late November or early December, probably. November/December time frame probably.

Right?

MR. GRIFFON: Right.

DR. ZIEMER: Okay, so --

MR. ELLIOTT: So I understand this, the expectation would be to have the Board review the scope of work and the evaluation plan. The working group's developing -- or has developed at that point in time the business plan and you're anticipating that then the whole package could be submitted to procurement until you have the opportunity to meet in executive session to review and approve the business plan, the RFP would not go further than necessary through procurement. And it's the --

DR. ZIEMER: Full Board would not have seen the business plan.

MR. ELLIOTT: Full Board would not have seen the business plan and the full Board would, in effect, review and approve that at the first opportunity -- this Board meeting in January -- in an executive session. What I need to find out is what's that control point internally for when it wouldn't move any farther. And it may be right at the start -- at the front door. Okay?

DR. ZIEMER: And if that's the case, that's how it'll have to be.

MR. ELLIOTT: That's how it'll have to be, so they may not take any action on it at all. I'm working on trying to figure that out.

MR. PRESLEY: Can --

DR. ZIEMER: Robert.

MR. PRESLEY: Can we go ahead and set a conference call date up now, sometime the first week in December?

MR. GRIFFON: Yeah, what I -- yeah, what I --

MR. PRESLEY: Let's go ahead and do that, and that way it'll help Cori, and we've got everybody here, almost, that can tell us what their schedules are, and let's go ahead --

DR. ZIEMER: Set aside two hours or more?

MR. GRIFFON: No, it's a lot of detail, probably, so maybe three hours.

MR. ELLIOTT: Is it your intention to submit -- the working group to submit the -- your final document in advance of this conference call so that they can review it and have been prepared with their questions? That'll cut down the time.

MR. GRIFFON: Yeah. We'll circulate it -- we'll try to circulate it a week in advance.

MR. ELLIOTT: We would want to put that on

the web site, as well, because it's a public meeting and so the discussion documents that would be used in that need to be available to the public.

MR. GRIFFON: Do they have to be available 30 days prior to the...

MR. ELLIOTT: The discussion documents -- I don't believe.

MR. GRIFFON: Of course, yeah, yeah.

MR. PRESLEY: Larry, how long does it take you to put something like that on the web?

MR. ELLIOTT: A matter of half a day.

MR. PRESLEY: Okay.

MR. GRIFFON: That's fine, so let's look for dates the first week in December.

MR. ELLIOTT: Henry can't meet on the 3rd or the 5th or the 6th. He's available the 2nd and the 4th, and anytime during the week of the 9th.

DR. ZIEMER: The only day I have open that week is the 2nd.

UNIDENTIFIED: Let's do it --

DR. ZIEMER: The 2nd?

DR. DEHART: I'm out.

DR. ZIEMER: You're out on the 2nd. How about November 30? Is that too early?

MR. PRESLEY: 2nd of December's a Sunday.

No, wait a minute, I'm sorry. I'm looking at the wrong one.

MR. GRIFFON: The 29th, is that Thanksgiving Day weekend?

DR. ZIEMER: Yeah, okay, so let's -- how about the 9th of December?

DR. ROESSLER: I'm out.

DR. ZIEMER: 10th?

DR. ROESSLER: Out.

DR. ZIEMER: 11th?

DR. ROESSLER: Out.

DR. ZIEMER: 12?

DR. ROESSLER: Yeah.

DR. ZIEMER: How's 12? You're okay with that?

MR. ESPINOSA: What was wrong with the 4th?

DR. ZIEMER: Several of us were out on the 4th.

UNIDENTIFIED: Roy's out.

DR. ZIEMER: Roy's out, I'm out. 12? Is it the 12th?

MR. GRIFFON: December 12th at 1:00 p.m. eastern time -- or are we talking eastern time?

DR. ZIEMER: 1:00 p.m. eastern standard time.

MS. HOMER: Two hours?

DR. ZIEMER: Okay. Everybody has that then on their calendar.

DR. MELIUS: Would someone repeat for me the contingency date for February?

UNIDENTIFIED: February 5th and 6th.

DR. MELIUS: 5th and 6th, thank you. The contingency of the follow-- second meeting, whatever we're calling it. I shouldn't have called it contingency.

MR. GRIFFON: And do we need an agenda for that conference call to put in the public record?

DR. ZIEMER: Yes.

MR. GRIFFON: I guess it would be --

DR. ZIEMER: Agenda item -- it's going to be a one-item agenda.

MR. GRIFFON: Well, two items, I guess, the techni-- or...

DR. ZIEMER: Well, it's one item with two parts.

MR. GRIFFON: Right.

MR. ELLIOTT: To discuss the RFP.

DR. ZIEMER: Yeah, that's it.

MR. GRIFFON: That's fine. I just wanted (inaudible).

DR. ZIEMER: You can give her the agenda today. Thank you.

Now, having done that, I think we need to -- we do have some other housekeeping items, but in fairness to members of the public who asked to be -- well, actually I haven't received -- are there any requests for this afternoon? The public comment period was scheduled for 3:45 and we appreciate the -- those who have been willing to delay briefly.

PUBLIC COMMENT PERIOD

Okay, I'll take these in order. I think Phil Scofield we heard from this morning. I think this was on the morning list, so Mike Schaeffer, you're up, I think.

MR. SCHAEFFER: I just have some brief comments, kind of postscript to being here for two days. One is on the consideration for the task to review -- independently review dose reconstructions. One of the key tasks of course was task four, to look at the SEC petition profile. And the question I have is, would that also include some means to review the NIOSH decision as to whether or not dose reconstructions could be performed or not?

DR. ZIEMER: One of the group want to answer that?

MR. GRIFFON: No. I don't know that we can answer that. I mean you've mentioned this earlier to me. I think we should consider it. We haven't seen -- seen the final SEC rule, so --

MR. SCHAEFFER: Yeah, we realize that I'm asking this question in anticipation of what your final 42 CFR part 83 rule is going to look like, but if there is some means of deciding when dose reconstructions can or cannot be performed, at least if that is a item that goes into the 42 CFR part 18 final rule that also is part of the checkout of the -- the independent checkout of the dose reconstructions, that that, too, be a provision.

DR. ZIEMER: It's certainly been an item of discussion, Mike, so we appreciate your comment on that.

MR. SCHAEFFER: Next one is, I wanted to recognize that the VA, of course, Department of Veterans Affairs, initiated and funded the task to update the radioepidemiological tables from 1986 that resulted of course in the IREP product that you all are using with some modifications. Likewise, the Department of Veterans Affairs has an advisory committee much like yourselves that oversee the application of such things as the IREP table.

Should there not be some means between say this committee and the committee that the VA has to at least open up some line of communications concerning the implementation of IREP and the changes that are going to of course come along? Obviously the VA has had some concerns in how just to implement IREP, and they're going to be reconvening their particular advisory board in December. My recommendation would be that both of the advisory boards provide at least some observer to each other in terms of sharing some of the concerns of implementing changes to IREP.

DR. ZIEMER: Mike, could you be sure to make available to us the schedule of that group so that we can at least --

MR. SCHAEFFER: I most certainly will.

DR. ZIEMER: Appreciate that.

MR. SCHAEFFER: The last item really owes from -- goes back to the fact that we also have an independent process on our dose reconstruction being performed by the National Academy of Sciences. And of course they've boiled down the task to two very, very key issues, is one, are the dose reconstructions we perform correct, are they right; and second of all, are they fair.

It looks like in your consideration for an

independent review process that you've done a very, very good job in considering how to evaluate and assess whether the dose reconstructions are right. We think it would also be useful to -- at least for the general public who is going to be having claims heard through your process, that there be some means of evaluating that there's some degree of customer satisfaction and fairness through the process. We think that's also a very, very key item, even though it's a non-technical item, that I think is very, very important to assess the well-being of the program.

DR. ZIEMER: Thank you very much. Next we'll hear from Alex Smith. Alex.

MR. SMITH: I'm from New Mexico, just south of here about 30 miles. I worked for LANL for 35 years and retired in 1982, from 1947 to 1982. And this morning I kept hearing the year 1952, and as a claimant, I am concerned about the period prior to 1952. I'm talking about the years 1947 to 1952 when I became contaminated with mercury and asbestos and perhaps radiation. Is research and investigation going to reach back that far when working -- when working conditions at LANL were sub-standard and compared to today's standards would be considered

quite hazardous, or are we talking 1952 until the present?

DR. ZIEMER: I think we can get an answer to that right away and Jim here --

DR. NETON: Yeah, I think I can answer the question. The 1952 I believe that you saw on the site profile chart that I showed was what we actually had received from the site itself, and I think if you noticed, that bar was not 100 percent, so they're missing -- there's missing information, and that would include that 1947 to '52 period. And I would say even today, as we speak, there are people up at Los Alamos that work for NIOSH looking at records in that specific time frame and we're going to capture as many of those records as we can, so they're certainly going to be looked at.

MR. SMITH: There's not too many of us left, you know.

DR. NETON: I understand. But there are log books, my understanding, that outline the dosimetry results for people in that time frame, and other records that we're pursuing.

MR. SMITH: Thank you very much.

DR. NETON: You're welcome.

DR. ZIEMER: Next we'll hear from Bob Tabor.

Bob?

MR. TABOR: (Inaudible)

DR. ZIEMER: Well, Bob, you signed up. We didn't twist your arm.

MR. TABOR: Yeah. Well, I'm not going to go through that long rendition of who I am. I've been here quite often. I want to chime in on something that I believe Phillip chimed in on earlier today that deals with the IREP model. And I guess the way I look at this is I'm not a scientist and so I like to put it in terms of more from what I would just call kind of a common sense perspective.

I look at it somewhat like apples and oranges, and I guess my -- my concerns deal with more so the process, maybe the philosophy, the strategy, the dynamics by which, you know, the model might have been developed. And as I said, I look at it somewhat as apples and oranges.

The nuclear worker, he wasn't at Hiroshima and Nagasaki when the A-bombs was dropped. The nuclear worker, he was not the larger part of the national public. Therefore I would say that the NCI studies and that particular type of model is not probably the most representative and applicable model for the nuclear worker's issues.

Now you've got on one hand over here -- let me just say -- let's call it Bob's best book on fruit farming, and you're in the apple growing business. And over here you've got Bob's best book on how to grow apples. My common sense says that what's most applicable is that of what deals with how to grow apples.

Okay. My point is simply this, folks. I find that the IREP model was lacking. Where is the worker epidemiological studies? You know, there's -- apples and oranges are fruit, but there's a difference between apples and oranges. And I think you probably get my point on that, so that's all I got to say to that.

Yesterday I touched on a comment -- I touched on the issue of credibility. I would just like to remind us that that, in my mind, is a -- is a very serious issue. And if we have issues relative to conflict of interest, which we've discussed a lot here in the last two days, and have heard a lot of new things. And issues on disclosure and maybe transparency issues and those type of things, all's I would urge us to do is to be sure that we really look at the root cause of things if we have those issues and not to do a band-aid effect

but to really find the -- you know, a good solution to those things. And I guess that basically ends my comment, and I learned a lot, so thanks.

DR. ZIEMER: Bob. Oh, I didn't give the Board opportunity to ask questions of Bob, Mike or Alex. Any questions?

(No responses)

DR. ZIEMER: Okay, we'll continue then. Let's see is it Paul -- is it Montoya? I have a little trouble reading everybody's handwriting. Paul is a former LANL employee from Espanola, New Mexico. If you'd use the mike, please, Paul.

MR. MONTOYA: Yes, thank you for giving me the opportunity to make a comment out here. I went to work at the Laboratory -- for Los Alamos National Laboratory in 1962 in the powder* metallurgy group and also in the fabrication group, also -- or rather in the casting or foundry, and I worked all my 31 years -- I retired in 1993, November, 1993 and so that was a total of 31 years. And throughout all that time I worked with beryllium. My first 15 years I worked in the powder form beryllium and the second 15 years I worked in the metal form and it was all casting, a little bit of assembly work. And also I worked with plutonium A-239*, a little bit of

238. And also -- I also worked with U-235 my whole years.

And the reason that I'm out here today, I do have a -- I was diagnosed at the National Jewish Hospital in Denver as having -- and also with John (sic) Hopkins University as having beryllium sensitivity. I do have also a body burden -- what they call a body burden of -- and I do have like five molecules of americium 240 in my lungs.

However, the Department of Energy rules that that's -- that's not sufficient, but in the eyes of the attorney -- of an attorney, that's more than enough. As I quoted it to -- one time in -- I had a meeting with an associate director of the National Laboratory and that's how much they care. He told me that -- what's wrong with a body burden? And I told him, how would you like to have one?

So -- but anyway -- and I went up there for a ten-minute meeting. He said you're interrupting two days. It ended up a meeting of two days. And you know, a lot of these people, they're disrespectful and that's why the Laboratory really -- they're having problems. I could be over here -- and that's why a lot of things went bad.

And so that's the reason -- okay, I retired

in 1993. In 1994, in February, 1994, myself and two co-workers that worked with me -- Harold Archuleta and Lepio* Garcia -- we went around out there. We hand-delivered a letter to Bill Richardson, the Congressman, and we asked him to come up with a compensation bill, which he did, but then he moved on to -- so then he turned the whole thing over to Jeff Bingaman.

Jeff Bingaman has been very good to us. He came up with a compensation bill and it went on and on and now -- now -- he went ahead and -- and also came up with the -- in which is last -- sometime last week where it will cover me. Also if I have beryllium sensitivity.

And right now what -- and the reason that I am out here is because all this -- all this compensation bill that is intended to help us people, the workers, it's not working. And the reason it's not working because the bureaucrats got involved in it. They appropriated $226 million for this compensation. Now everybody's got their hands in the cookie jar, and that's -- that's very true. And the reason --

Okay, so when this bill came up, the way the language was written up, it said okay, we will go

ahead and pay off these claims with the Department of Labor. However, okay, the Department of Labor, okay. (Inaudible) appeal (inaudible) the appeal (inaudible) that is going to deny your claim was going to hear the appeal.

Okay, so the whole (inaudible) idea. I hired an attorney. I signed a letter of representation. Today if I call the Department of Labor in Denver or wherever, I can't even get the time of day. And the reason is because I signed -- they told me that I signed a legal representation and the reason that I signed a legal representation was on -- upon advice of the attorney, my attorney. And my attorney said okay, in other words, the reason -- well, what -- if these people over there at the office in Espanola, if they fill out the form, are they going to (inaudible) will have to go out there under an appeal.

Okay, so I went through the whole process. I was denied. Okay? So when I (inaudible) my attorney and my attorney said there's nothing to appeal. It says the same person, you stand a chance like a snowball in Hell, you know, so the same person at the Department of Labor denied your appeal -- I mean denied your claim, they're going to be

hearing -- so we're wasting our time.

So what we would like to do, like I told Jeff Bingaman, we want to make this thing work. Okay? And that's exactly what we need and so we would -- what we would like to do is compensate all these people that -- that have -- they deserve -- half -- or maybe -- mostly all my co-workers, they're gone. They're gone. And nobody likes to hear the word AIDS. Okay? But in comparison -- the way -- the way a doctor described it to me at the National Jewish Hospital is if you have beryllium sensitivity, that's -- that's compared -- compared to HIV, which would be -- so in other words, it's a -- in other words, it's a foot in the grave. How long -- it's not a matter of if, it's a matter of when, you know. It's -- in other words --

So I would like to ask you that -- to please get this bill going. And like Jeff Bingaman, I have a lot of faith in God and I know that Jeff Bingaman -- and he promised me and he said that it would be covered and my -- he said you -- you will get your compensation. And there's no matter what -- nobody can tell me how sick I am or whether I have the potential of dying through this illness and so forth.

You know, so in other words, it's a -- it's a -- it's a -- the burden of proof. In other words, right now the burden of proof is on us right now, and what -- we would like to have the burden of proof on these people (inaudible) making claims. I feel that this -- that by having the Department of Labor -- and as a matter of fact, I recommended that to Congressman Udall and also to Jeff Bingaman. I told them that the Department of Labor shouldn't be involved in this. They should give it to an accounting firm and that'd be -- that would be about the right way 'cause it doesn't matter how -- they're going to try to beat you out of something that you have coming, so I -- I -- giving -- thing -- I'm sorry that I took a little bit of time -- of your time, but I sure thank you for giving me the opportunity, so thank you.

DR. ZIEMER: Thank you very much. We certainly appreciate the frustration you feel. It sounds like you've enlisted some pretty strong help with the Congressional people to -- so maybe they will be successful in addressing this issue in your behalf.

Let's see, I have next -- oh, are there questions from any of the Board members?

(No responses)

DR. ZIEMER: I think Ken Silver is next on the list. Ken.

MR. SILVER: I'm sure it's okay with you if I allow B. Jo* Baer to speak.

DR. ZIEMER: Oh, yes, I have her on the list, and she's certainly welcome to go -- I just was taking them in the order they were handed. You're welcome to go next. And it's B. Jo --

MS. BAER: B. Jo Baer, and my husband was a nuclear physicist at the Los Alamos National Lab in the seventies to the -- to 1991 when he died. He died of lung cancer and had never smoked a cigarette in his life and was a very healthy man with healthy habits. I'm a claimant, and I have a question that is very personal and I don't -- I hope I'm not taking time asking my personal question, but it has to do with record-keeping and it has to do with credibility and it has to do with my unfortunate lack of total confidence in this government process.

I filled out my application and it's very large and I was lucky to get records that other people weren't able to get, so I know how difficult it is to get records and I know that when I read the law, it said that when -- that the decision would be

made depending -- if a person's cancer or illness was at least as likely to have been caused by work at the Lab. And then I don't understand what dose -- how you do dose reconstructions, but then -- but I do understand it's becoming harder -- it seems to be becoming harder and harder to provide the information that you -- that is needed in order to do a credible dose reconstruction because I don't have -- myself, as a claimant -- access to all the information that's needed.

However, several, several months ago I received a telephone call -- or a letter that things were moving along and that I might be on the list of people to be interviewed, or maybe I had a letter and I didn't -- wasn't -- it wasn't (inaudible) to me. I made a telephone call to Denver and I was told that some records had come from DOE that was going -- that would be used for the dose reconstruction, and I asked for a copy of those records because I would like to have in my possession the same information that -- that the people who were doing dose reconstruction have -- I mean if it's possible. And then I -- that's a -- that's a fair question -- fair request. And I -- thank you.

So -- but I was told that what I had to do was fill out a form and go through DOE and apply for public -- you know, what is it, Freedom of Information Act. And I said I don't want to do that. I want to know what you have. I want to know what they gave you. And that sounds like that's okay? I don't have -- okay. So --

DR. ZIEMER: And we probably won't want to discuss the details of your --

MS. BAER: No.

DR. ZIEMER: -- case here in --

MS. BAER: No, absolutely not.

DR. ZIEMER: -- this sort of forum, but in terms of gathering information -- and maybe Jim or Larry can address that -- but in fact the burden is not on you to come up with the records. We do like to obtain records that survivors may have. Sometimes they know some things that maybe are a little difficult to learn otherwise. But the burden is on NIOSH to -- and DOE to come up with those records.

Could we ask either Larry Elliott or Jim to -- on the NIOSH staff to address those questions. Jim?

DR. NETON: Dr. Ziemer's correct. It is

NIOSH's responsibility to obtain the records, not the claimant's, as I think I indicated yesterday. The claimant's certainly -- it's acceptable for a claimant to obtain the records and to review them. That's their right, but it is really our burden to request the information from the Department of Energy.

I'm somewhat confused regarding the way things occurred in this particular case. I believe you indicated that the Department of Labor informed you that they had the Department of Energy records that they'd just received. That is not the usual means by which we obtain records. The Department of Labor would forward a claim to us, at which point we would issue a request to the Department of Energy for your exposure -- or your father -- or husband's exposure records.

MS. BAER: Well, I meant to say that the Department of Energy had given the -- had provided the information that was needed. But when I asked for a copy of the information, I was told I would have to go through some Freedom of Information Act procedure.

DR. NETON: Well -- right, I understand what you're saying. But it's unusual for the Department

of Energy to send exposure records directly to the Department of Labor. That is not the normal mechanism.

MS. BAER: Oh.

DR. NETON: The Department of Labor merely establishes an employment at the covered facility and the diagnosis of a cancer.

MS. BAER: Maybe it was from the Lab that they got them.

DR. NETON: Well, they shouldn't have. I mean not -- sometimes mistakes do happen or maybe records were sent to the wrong location, but the normal mechanism is that we would request -- NIOSH -- the exposure records for your --

MS. BAER: Husband.

DR. NETON: -- your husband. And then once we receive those records, call to schedule an interview with the claimant.

MS. BAER: Well, the -- if I -- excuse me. My understanding was you called whoever you were supposed to call and you got the record, and I then asked for a copy of the records, and I was told -- and that's really -- that's really my question.

DR. NETON: If you did call the Department -- if you did call NIOSH and we had the records, we

-- certainly it's not our policy to instruct you to go to the Department of Energy to obtain copies of those records. We would provide them to you, given the appropriate paperwork were filled out in our organization.

MS. BAER: Well, I have on my answering machine a recording of the woman who called and told me she'd tell me how to go through the Freedom of Information Act, so I have her name and her telephone number.

DR. NETON: Well, perhaps after the meeting we could talk and you could give me that information and I'll exchange my phone number with you and we could discuss it.

MS. BAER: Okay. So what I'm understanding is that I -- it is okay for me to have that information that you're using to make your decision.

DR. NETON: Absolutely.

MS. BAER: That's what I --

MR. ELLIOTT: Just to add to that, of course you're allowed to have that information and it will be provided to you. It will also be available in the administrative record that goes with our determination of the dose reconstruction to the Department of Labor for the final decision, and so

you'd have access to that, as well. And as we talked in Cincinnati before we boarded the plane to come out here, we're -- we'll check on this issue about the interview and we'll get back to you. You'll get a call later from me or Jim.

MS. BAER: Thank you very much.

DR. ZIEMER: Okay. And then Ken, you still wish to address the group. Thank you.

MR. SILVER: We're always very impressed when members of a public body like this stay until the late afternoon to hear public comment, so thank you all.

A few quick points. I was mentioned that someone yesterday referred to ORISE or ORAU as a major DOE contractor. We're well aware that it never has been and is not now an M&O contractor. But in the world of health physics and epidemiologic studies, which is why we're all here, of course it's a major contractor to DOE.

One simple example, a DOE contractor with history associates some years back to compile finding aids to epidemiologically relevant record series. Hanford filled several volumes, Savannah River, Los Alamos, a big three-ring binder, and they took their time to do a separate binder for ORISE

because it has had a central role in health studies in DOE facilities for many years. There's a lot of expertise there, but we need to balance that with public concerns about conflict of interest.

There are other stakeholders in this program and in fact the stakeholders who made this program a reality, the folks you've heard from, PACE* Union, the building trades. And they have some very good, innovative ideas for how to build public confidence in dose reconstruction. PACE has pioneered public worker participation in exposure assessment, methodologies, and it's really time for a fresh look at some of these old DOE sites. And if we put all our reliance on ORISE, we wouldn't get that.

Secondly, you've heard how important it is to not take documents that you get from LANL at face value. I would argue you need to take workers at face value and to just dig and dig and dig in the course of trying to document people's exposures.

I wasn't in the room when Alex Smith began his talk, but at a public meeting like this in March of 2000 he described a mercury poisoning incident occurring in the late 1940's. The Lab, throughout his subsequent career, denied it had ever occurred. And some of us took the time to dig into DOE records

and lo and behold found extensive documentation from Harriet Hardy* in one year that she spent at Los Alamos in 1948 of that very contamination incident.

Another example of why it's important to dig and dig at Los Alamos, we had a spike in thyroid cancer in Los Alamos County in the late 1980's or early 1990's, so serious public and scientific concern focused on the research reactors located in the middle of town. Omega west reactor was five megawatts when built, increased to eight megawatts in the late 1960's under a national security exemption. The stack was 200 feet tall, but since the reactor was down in the canyon, that meant it vented essentially at ground level.

We're not aware of any fuel failures at Omega west, but ran across a memo in 1971 where a bunch of people from H-1, the radiologic health group arrived at the reactor to find that the surge tank valve was open. And we found that -- and the entire rest of the sentence is blacked out on the best available copy.

So this is a plea to NIOSH and your contractors to not be satisfied with this kind of thing, but to dig and dig and dig, and listen to what the workers have to tell you. Like Alex Smith,

the documentation may not be in hand, but the story was very, very real.

Another example, in the late 1960's DP* west was the Lab's major plutonium facility. A major production push was on throughout the complex in 1969. And if you were satisfied with the official emissions inventory in the community reading room, you might believe that room 401, the hot cell, was not in use in 1969.

But if you dig a little deeper, use the Freedom of Information Act, in fact there was a major increase in plutonium counts in the room air of room 401 and possible fission products, as well. In a column of two and three-digit numbers, there is some seven, eight and nine-digit numbers on these monitoring reports, with a little notation that says these figures should not be recorded in annual report.

And we're still at a loss to figure out what happened in room 401 at DP west in July of 1969. We're hoping that some of the workers will now talk to us and some of the monitors will open up about why these figures should not be recorded in annual report.

Los Alamos is particularly problematic when

it comes to access to historical documents, so we're going to be watching you very, very carefully on that phase of the dose reconstruction.

I also wanted to mention the frustration the families feel in interpreting some of the documentation. A sheet metal worker whose family spoke very passionately yesterday, 1950 he's documented to have had moderate exposure to some hazard in 11 of 12 months of the calendar year.

What is the hazard? Well, it's something with a code number 49. We're pretty sure it's not his technical area. Among the other hazards that he was not exposed to are polonium, tube alloy*, TNT. We know what all those are. But what in the world was hazard 49? And why in the world are there no dosimetry readings in his personal report for the year 1950?

So this is a plea for some serious independent technical assistance in helping families understand what this is all about. Thank you.

DR. ZIEMER: Thank you very much for that input. Again I'll ask if any of the Board members have questions?

(No responses)

DR. ZIEMER: Okay. We thank all those who

did stay to participate and provide their comments, and those again will all be on the record, as well.

UNIDENTIFIED: Excuse me, we've just been notified that Congressman Udall's office has a brief statement.

DR. ZIEMER: Oh, okay. Yes, I hadn't been informed of that. We'd be pleased to hear from representatives of the Congressman's office. And you'll need to give us your name for the record.

MR. VASQUEZ: My name's Robert Vasquez and I work for Congressman Tom Udall. And this is just a brief statement from his office.

Congressman Tom Udall, who represents northern New Mexico in Congress, and many of the constituents who work -- worked and work for Los Alamos National Labs has been closely monitoring the legislation and how the program is being carried out. Congressman Udall is one of the original co-sponsors of the EEOICA (sic). The Congressman is co-sponsoring the Strickland Bill to some of the flaws in the Act -- to address some of the flaws in the Act, I'm sorry.

There are many compelling arguments to support why LANL or LANL groups should be designated as a special cohort. We understand that the

catalyst to the process will really be the release of the regulations in January, 2003. However, we'd like to say that Congressman Udall will be investigating ways to allow LANL to be so designated as a Special Exposure Cohort. Thank you.

DR. ZIEMER: Thank you very much, and please note that the Board does appreciate the ongoing interest of his office in this process.

ADMINISTRATIVE HOUSEKEEPING

I want us to return now to the housekeeping issues. Cori, could you -- and/or Jim, help us with what other things we need to do. I think -- I know that you all need to provide Larry with your hours -- preparation hours and other time spent beyond the meeting times. Right?

Be sure to include your name. If you're not sure of your name, just put it under mine.

(Pause)

DR. ZIEMER: There is a section called housekeeping, and --

MS. HOMER: There should be an action item which I believe you've already seen. And I'll try to make this really quick.

DR. ZIEMER: I think we're looking at the table --

MS. HOMER: How's that?

DR. ZIEMER: The table. Right? Under action --

MS. HOMER: Yes.

DR. ZIEMER: -- items, you see the table where we have the running list of action items and their status.

MS. HOMER: And you can tell that there's been a little bit of a structural change to it. What we are hoping to do is to be able to define things a little better for everybody with the action items listing. Wanted to be very specific about the items and the status, and identify whether it was the Board's action item or agenda item, or whether it was NIOSH's item to deal with. And we have -- as soon as it -- let me see if I can get this up. Where is it?

UNIDENTIFIED: What?

MS. HOMER: The action items listing. It's not here.

UNIDENTIFIED: I don't have it.

MS. HOMER: You don't have it? I gave it to Chris. Oh, well, I guess I'm winging it, folks.

UNIDENTIFIED: There's a hard copy.

MS. HOMER: There is a hard copy in your

book. As you can see, we've divided it by meeting, by date and status. In order to keep this less -- at least somewhat simple, as each item has been completed and identified as completed, it will show up on the next meeting's action items listing, then it will disappear. Well, not exactly disappear. What we're going to do is move it to a completed action items listing, so we will be able to keep track of everything that's been done, the day it was completed, et cetera. But if we were to bring a running action items list to the Board every time, it would become unmanageable very quickly.

Each action item on this listing is something that the Board has provided consensus on. The action items are not for individual -- individuals requests. It has to be brought to the attention of the Board and discussed and voted on for it to make it to the action items listing.

MR. ELLIOTT: Or maybe not voted on, but at least there's a sense of the Board that it's --

MS. HOMER: Well, yeah, sense of the Board, provided that -- you know, most folks really want this on there.

We have decided that NIOSH is going to manage this action items listing and provide it to

be attached to the minutes so that it's still provided prior to the meeting. What we're going to do is, with the assistance of the writer/editor and the court reporter, as well as NIOSH staff and the Board, we're going to try and cover everything from every meeting to make sure that everything that -- we have a sense of the Board -- that it makes it to the action items listing. We just want to make sure that that's everything that has been requested is covered.

I think that's about all I have, Larry.

DR. MELIUS: Can I just -- a question to make sure I understood you, but if you look at the first page there, it's under meeting four --

MS. HOMER: Uh-huh.

DR. MELIUS: -- item number two, or let's take an even quicker on. Number four, e-member -- e-mail members about web site. That I don't think needs to stay on the list. It's something -- you've instituted a policy of -- procedure for doing that now. We are now getting those.

MS. HOMER: Okay.

DR. MELIUS: To me, that would be something that I'd just take off 'cause it's a procedural change and I think it just clutters up, and if we

forget to --

DR. ZIEMER: Some of those ongoing things are probably in that category.

MS. HOMER: Well, we'd also planned on providing this information to you in a house -- under the housekeeping section of the agenda at every meeting so that we all have an opportunity to comment on what can be taken off, what should be left on. There may be some items that are ongoing that you want kept in front of the Board and the public and -- on a consistent basis.

DR. MELIUS: Yeah. And the other thing I'd suggest we -- I mentioned earlier today is I think it would be helpful with some of these -- we have some things like further information on IREP and, you know, some was -- Dr. Land presenting and so forth, but there are a number of issues that had been brought up and suggested that we haven't gotten to, and I think if we did -- a working group would help us sort of consolidate those issues, work with you in terms of scheduling if there are appropriate outside speakers or something to come to Board meetings and so forth, and maybe that's a better way of dealing with that issue than -- rather than keeping this as an ongoing thing. And since Henry

did leave, we certainly will volun-- I will volunteer him for that committee.

DR. ZIEMER: Is it also possible to cross-sort the -- and this is helpful, they're sort of sequentially here, but maybe this is partially what you're -- have in mind, but for example, a table that had the IREP items is pulled out of this. In other words, a topical table as a quick cross-sorter, a crosswalk* of these. So if you said well, what open items do we have in IREP, it would be there, what other items do we have --

MS. HOMER: Okay, we can do that. That's should be -- that should be very easy.

DR. ZIEMER: That's something you could do. That would help address what your concern is, Jim.

Jim, it wasn't clear to me at this point, though. Were you making a formal motion on an action on IREP or --

DR. MELIUS: I was -- a formal motion or sense of the Board or whatever you want to do, but I guess I'm suggesting that we set up a working group on dealing with some of the IREP and scientific issues to try to work to I guess prepare the Board for dealing with some of these issues as they come up to -- to review -- we deal with some of the

scientific information that is ongoing, and actually some of our public comments today about how do we coordinate what our activities and what our -- what NIOSH and what -- how we handle IREP with what some of the other groups are, the VA and so forth in dealing with it. I think that working group could work on some of those issues, also, and I think it would be helpful.

MS. HOMER: There's a difference between a working group and a subcommittee, and it sounds to me like what you're proposing might be something of a subcommittee. Working group has one task and short term. A subcommittee is something a little bit longer term or very much longer term.

DR. MELIUS: Well, let's charge a working group with coming up by the next meeting with a proposal for whether this needs to be dealt with through a subcommittee or what's the right best procedure for doing -- for handling some of these issues.

DR. ZIEMER: On an ongoing basis.

DR. MELIUS: On an ongoing basis.

DR. ZIEMER: So you're looking at a work group to simply come up with a more solid proposal.

DR. MELIUS: Right. And then if it needs to

be a subcommittee, we can decide and some issues with that, yeah.

DR. ZIEMER: It would be appropriate for you to make a motion to that effect, and the content of the motion would become basically the charge to the committee, I think. So if you want to give us a formal motion.

DR. MELIUS: Yeah, I would move that the -- we establish a working group to come up with recommendations to the Board at its next -- at our next meeting -- next full meeting, personal meeting rather than the conference call meeting, regarding a number of issues related to IREP, as well as our coordination of IREP issues with some of the other government groups that are dealing with the IREP model.

DR. ZIEMER: Is there a second?

MR. ESPINOSA: I'll second.

DR. ZIEMER: Seconded. Is there discussion on this motion? Tony.

DR. ANDRADE: I question even the necessity for having any group deal with -- have to deal with IREP issues from this particular Board when we have NIOSH staff that deals directly with SENES and provides us with very timely updates, I believe,

with respect to models in IREP, how they are implemented, and the effects that those implementations may have on POC. Hence, I'm not too terribly enthusiastic about spreading ourselves even thinner in either a working group or subcommittee.

DR. MELIUS: Can I respond to that?

DR. ZIEMER: Yes.

DR. MELIUS: Yeah, I was not proposing to replace any of the activities of the NIOSH staff or -- nor to provide any sense of an ongoing update regarding IREP issues. However, there have been a number of issues that we've been brought up several times at these meetings that we have requested clarification on and briefing on. I thought we had all agreed to at meetings -- issues regarding -- and have come up -- some of them have been brought up today by the general public, the how do we deal with occupational studies in relationship to IREP, how do we deal with toxic exposures in relationship to radiation exposures in IREP, how do we deal with some of the scientific issues -- age at exposure, for example, things like that. And I would just like -- think it would be helpful -- I think helpful both to NIOSH staff and to the Board to have some sort of a plan for what extent we -- how do we get

briefed on some of those issues, how do we deal with those issues. Do we just let them go and let -- wait until the NIOSH staff updates us on them, or are there some that we want to take a more active involvement at this point and lay out a plan. So -- proposing is a short term committee, working group, that would report back to the Board. And we can decide, is it -- you know, the scope of that appropriate and is the -- what should be the task, does it need to be ongoing or not.

DR. ZIEMER: Let's have other comments? Tony, you want to respond and then Wanda, will you --

MS. MUNN: I was going to say something.

DR. ZIEMER: Tony and then Wanda.

DR. ANDRADE: The issues that come about usually come about as a result of questions that are brought up by the public and/or this Board. And -- for example, the whole issue of whether we are relying solely on Japanese atomic bomb survivors data to do -- as data that is used in dose reconstructions or to model behavior of the human body with respect to radiation. That, since it was brought up today, could be -- we could easily solicit a briefing on that very topic for this --

for our upcoming meeting.

I just don't know if there's going to be a competent enough, qualified enough subsection of this working -- of this Advisory Board that's going to go out and, on its own, fish out, quote, issues with IREP. But you know, I know that Jim Neton could give us a very complete briefing on all of the data that is used in all of our models and could give the public a really good understanding of what's used.

And so I -- again, I think that we can handle these issues one at a time.

DR. ZIEMER: Okay. Wanda is next.

MS. MUNN: I'm comfortable with the level of information that NIOSH staff has been giving us. Added to that, our own working group is in the process of putting together another independent body which will audit what's been said and done all over again, so I'm quite happy with where we are.

DR. ZIEMER: Does anyone else wish to speak pro or con? Yes, Mark?

MR. GRIFFON: Yeah, I stepped out of the room so I'm assuming this is the proposed working group that Henry was going to -- no. I guess I feel that we -- we -- we tabled these IREP is-- we -- we

-- I know many IREP issues and we've had presentations on many that -- not issues, I shouldn't say, but areas for future consideration I guess is the way they've sort of been spelled out. But -- and in looking at the probability of causation and rules, I think everyone on the Board -- I think the sort of agreement was that specific comments for IREP could be tabled at this point, but it wouldn't be off the scope of work for the Board. And I think -- I think to have a working group that concentrated on those issues and maybe looked at them one at a time and laid out -- researched them a little bit to the extent that they could report back to the whole Board on what is the status of knowledge in this area and is it a priority for -- maybe the Board needs to talk about, or are certain things priorities for inclusion within the IREP model, are certain things longer term. I mean I think there's some stuff that a working group could have quite a bit of input on.

DR. ZIEMER: Mark, let me clarify. The motion that's before us is actually not a group that would do what you just described, but a group that would recommend whether we should have a group.

MR. GRIFFON: Oh.

DR. MELIUS: Would lay out -- let's lay out options for how we could address those, I think is a better --

DR. ZIEMER: Yeah, not that this would be the group to do it, but that it might, as one option, do what you just described.

Okay, who else had -- Larry.

MR. ELLIOTT: I'm not here to speak to how you wish to go about doing this, but I would like to share my interest in how you go about doing this.

It's been a dilemma for me in trying to set the agenda for your meetings with Dr. Ziemer, having this long list here that we've got before you of action items. And I'd just call -- maybe it's -- in my opinion, it's not just IREP. It's research-related issues that feed into IREP or don't feed into IREP. Some of these research interests feed into dose reconstruction methodology. So if you look at the action item list, you look at the -- on the first page, starting on the first page, you look at item number five, item number eight, you go to the second page you look at nine, you look at 14.

Those are what I'm having some difficulty in in trying to determine how soon do you need -- do you need presentations, how -- where is your feeling

at on prioritization of these things. We've got two meetings -- two face-to-face, two-day meetings scheduled now for the month of January and February, and I'm going to be looking forward to knowing what's the Board's interest and pleasure in filling those four days out, besides what we've already talked about with the SEC rule and this RFP.

So that's where I -- my perspective on this and where I'm coming from. I appreciate your help and I'm certainly -- will support whatever approach or process you decide.

DR. ZIEMER: Any others speaking pro or con? Yes, Wanda.

MS. MUNN: With respect to what Larry just brought to us, it appears to me that, given the new process for the action items and what Cori's going to be presenting to us, that perhaps one of the standard housekeeping items of this group could be at the end of our session, at this time, we could look at the current action items and suggest to Larry which of them we wanted on the agenda next. That would seem to be the most simple and direct way to address it.

DR. ZIEMER: Thank you. And speaking to the motion, are you ready to vote for the motion?

MR. GRIFFON: Can you just restate the motion? I'm sorry.

DR. MELIUS: The motion -- we would establish a working group that would report to the Board at our next full meeting that would present a series of recommendations on how we should -- the Board should prioritize and handle a number of these IREP and other scientific issues in relationship to future meetings.

DR. ZIEMER: I'm not sure that's exact wording of the initial motion, but it's close.

Okay, you ready to vote? It was seconded, was it not?

DR. MELIUS: Yeah.

DR. ZIEMER: Yeah. Okay. All in favor of serving on the working group say aye?

(Laughter)

DR. ZIEMER: Almost caught you. All who favor the motion say aye?

(Affirmative responses)

DR. ZIEMER: All opposed say no.

(Negative responses)

DR. ZIEMER: I think I'll declare that the ayes have it. Are there any abstentions?

DR. ANDRADE: I abstain.

DR. ZIEMER: One abstention. Okay. I believe the motion has passed by voice vote.

In addition to Jim and Henry -- Jim are you willing to chair --

DR. MELIUS: Yeah, I would.

DR. ZIEMER: Yeah, if you make the motion --

DR. MELIUS: I was -- yeah.

DR. ZIEMER: Are there others who want to volunteer to be on the work group? We need one or two additional people, I would say.

MR. ELLIOTT: I will serve as the staff liaison.

DR. ZIEMER: And Larry will serve as the staff liaison. Is there one or two other people? Just...

MR. OWENS: I'll volunteer.

DR. ZIEMER: Good, Leon. That's three plus Larry. If there's someone else and you just don't want to publicly admit how badly you want to serve on this group, we'll take volunteers later. But the working group now is Leon Owens -- it's Jim who will serve as chairman and Henry Anderson, Larry Elliott will serve as the staff liaison person. Thank you.

Are there other items that need to come before the Board at this session today?

(No responses)

DR. ZIEMER: Is there a motion to adjourn?

DR. DEHART: So move.

DR. ZIEMER: Is there a second?

MR. PRESLEY: Second.

DR. ZIEMER: All in favor say aye?

(Affirmative responses)

DR. ZIEMER: Motion carries, we are adjourned.

(Meeting adjourned at 4:45 p.m.)

C E R T I F I C A T E

STATE OF GEORGIA :

:

COUNTY OF FULTON :

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the 16th day of October, 2002; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 17th day of November, 2002.

STEVEN RAY GREEN,
CERTIFIED MERIT COURT REPORTER
CERTIFICATE NUMBER: A-2102