

1 little further then, with the fear of putting
2 my foot in it, but I mean -- I -- personally,
3 myself, I've had concerns -- ongoing concerns
4 that the interviews -- not only the -- not only
5 is the -- the questionnaire problematic up
6 front, but the interviews have -- have not been
7 considered a very important part of the overall
8 DR process and -- and are not really used. And
9 they fall on deaf ears. And there's evidence
10 of this. And -- and I know we've -- and I -- I
11 do see that you're making progress on this,
12 like the DR -- some of our findings relate to
13 the DR report and how you're correcting that to
14 address the fact that, you know, if someone
15 raised incidents, it didn't fa-- fall on deaf
16 ears. Actually, you know, the internal dose
17 assigned did actually bound, you know, these
18 incidents that -- but when you sta-- you know,
19 I think that just -- you know, just the fact
20 that, you know, many people go through the
21 trouble in their -- in these interview
22 processes of identifying coworkers, identifying
23 all these incidents and then they get their DR
24 report and nothing's mentioned of any of this.
25 And the procedure -- I don't -- and this I

1 guess is still being considered, this idea of a
2 trigger -- when -- when would you call a
3 coworker or contact a coworker or pull coworker
4 records to cross-walk a case. You know, four
5 or five years into this, I'm not sure there's a
6 clear process for that still.

7 **MR. HINNEFELD:** Right.

8 **MR. GRIFFON:** So I mean I -- I guess I'll go a
9 little further than Mike's -- I -- I believe
10 progress has been made but I -- I'm not sure
11 that more value couldn't -- couldn't have come
12 out of this process. And -- and then the other
13 -- I mean -- first of all, I think there --
14 there could be some technical value to it. But
15 then the second part is it -- it's critical, in
16 terms of communicating with the claimant, that
17 you're doing everything that you can to address
18 their specific concerns about their exposure.
19 It's an individual dose reconstruction, it's
20 not a -- you know, when you start getting
21 boilerplate responses, people say they didn't
22 consider the details I ga-- you know, so --

23 **MS. MUNN:** Well --

24 **MR. GRIFFON:** -- I guess I'll get off my --
25 that spot for a second.

1 **MS. MUNN:** But conversely, as true as that is,
2 it is also true that, human nature being what
3 it is, it's highly unlikely that an individual
4 with a probability of causation of 35 would
5 ever likely understand fully what that means,
6 nor would -- you -- you've all heard me harp on
7 this before, that we mislead the public by
8 leading them to believe that there is an
9 enormous amount of precision, and perhaps they
10 have not had all of their information
11 incorporated, when the truth of the matter is
12 they have been given every conceivable
13 additional added dose that anyone could
14 possibly dream of in order to give them the
15 benefit of every single doubt that's arisen in
16 the calculation. And it's -- it's --

17 **MR. GRIFFON:** Well, at least for the maximizing
18 ones, anyway.

19 **MS. MUNN:** Well, not only just the maximizing
20 ones, you know, we --

21 **MR. GIBSON:** Mark, this is Mike. Could I
22 respond? With all due respect, Wanda, as I
23 stated yesterday -- we may have a different
24 audience here today -- but, you know, all I
25 heard yesterday was when a worker says

1 something it's -- I think Brant used the word
2 "alleged". But then when I heard the words
3 from these people that worked at Rocky Flats in
4 the radiological protection program in various
5 capacities and managing -- management
6 capacities, you know, that made up basically
7 the site profile and everything else. But
8 whenever a worker or a claimant says something,
9 it's "alleged." And again, you know, and I
10 bes-- I stated this yesterday and I'll state it
11 again, I've asked how many workers, whether
12 they're hourly or salary, not in a management
13 capacity, have been used to develop site
14 profiles? So, you know, yes, granted, there
15 are some cases they -- NIOSH puts an upper
16 bound on limits, but in some cases how much are
17 these people listened to? And as Mark said,
18 how much is their information looked into?

19 **MR. GRIFFON:** I -- I mean -- I guess my fee--
20 and I don't -- I don't -- you know, the
21 efficiency process has its place in this
22 program and -- and there is this communication
23 problem, certainly. I don't disagree with
24 that. But I also think there's probably a
25 tendency to screen by cancer -- I -- I mean I'm

1 not sure exactly the efficiency mode but, you
2 know, there's obviously a -- probably a
3 tendency to screen by cancer type. And if
4 someone has a prostate cancer, automatically
5 you -- you probably don't even spend much time
6 with the incidents and at least it deserves to
7 be addressed and say, okay, you know,
8 everything here, even if -- even if they're all
9 -- let's assume they're all true, we're still
10 very bounding in our dose. And -- and then
11 that communicated to the -- and we've talked
12 about that one.

13 **MR. HINNEFELD:** Uh-huh.

14 **MR. GRIFFON:** So it's those types of things
15 that I think and -- and some, I guess -- at --
16 at least the perception and I -- and I -- you
17 know, I don't know that we've seen a lot of
18 cases where it looks as though specific things
19 have been looked into. So we -- we're still --
20 although we've been doing most overestimates --

21 **MR. HINNEFELD:** There -- there have been a
22 number of cases that have done that, but of
23 course with a hundred or so samples you
24 wouldn't necessarily have seen them.

25 **MR. GRIFFON:** Right, right. And we're looking

1 -- so far we've looked mainly at the
2 overestimating and the underestimating, which
3 wouldn't necessarily get into that coworker
4 interview as a follow-up on incidents or
5 anything like that. But I guess, you know,
6 some of the responses that we've heard from the
7 field from claimants is that they don't feel
8 that's being addressed. And you know, it may
9 not in every -- in all cases just be a matter
10 of adding in some boilerplate language that
11 says your incidents are covered by our 12-
12 nuclide model, you know. Sometimes, like Mike
13 said, you know, there is some there there and
14 you might look at those incidents and not
15 initially believe them, but see -- check into
16 it and say, wow, you know, we didn't realize
17 that happened at that site, you know, so -- but
18 anyway --

19 **MS. MUNN:** Or in cases where the individual
20 provides specific information about their job -
21 -

22 **MR. GRIFFON:** Right.

23 **MS. MUNN:** -- category, perhaps that can be
24 highlighted so that the closeout interviewer
25 refers to that and the -- the -- claimant does

1 not have the sense that they have been ignored
2 simply because it was not referred to.

3 **MR. GRIFFON:** And I -- I think there was --
4 this might be a broader problem for the full
5 Board but I mean the whole worker outreach
6 program, the -- the same question -- all the
7 questions that are raised in these worker
8 outreach program -- you know, I'm -- I'm
9 hearing from people in the field that they're
10 saying well, we went through this whole
11 process, we went through this whole meeting, we
12 raised a lot of questions and it's been 12
13 months and the site profile version's the same,
14 so we assume nothing's happening with it, you
15 know. That's -- that's the question, you know,
16 are these things flagged like, you know, if
17 they find something specific in these meetings
18 or in the individual interviews, flagged and do
19 they make a difference in the path forward with
20 the DR. And you know, at least a lot of
21 people's perception now is that, you know, that
22 it -- that's it's not, so...

23 **DR. MAKHIJANI:** Mark, it may be -- you know,
24 this -- this -- I think the initial packet and
25 what NIOSH promises in that packet in the

1 context of the CATI -- very important, you
2 know. I guess most the interviews are done,
3 but whatever remains in that, I think -- I
4 think there should be some commitment to
5 explain how the dose reconstruction is related
6 or not related to the radiological-related
7 items in the interview. So -- so that when
8 that there is a dose reconstruction report, it
9 isn't silent on -- on these items. Just what
10 you were saying, that there -- there is a
11 bulleted list, you said -- and --

12 **MR. GRIFFON:** Yeah. And I think --

13 **DR. MAKHIJANI:** -- we didn't do this incident
14 because --

15 **MR. GRIFFON:** -- this came up in our cases.
16 Right?

17 **MS. BEHLING:** Yes.

18 **MR. GRIFFON:** And Stu, I believe you made a --
19 a preliminary commitment to modify DR language,
20 I think was one of the actions.

21 **MR. HINNEFELD:** Yeah. I've got a draft on my
22 desk.

23 **MR. GRIFFON:** Right, right, right. So you have
24 -- you are considering that, I think.

25 **DR. MAKHIJANI:** But I -- but I think that could

1 be --

2 **MR. HINNEFELD:** Yeah.

3 **DR. MAKHIJANI:** -- that could be part of this.
4 What -- what the claimant knows initially about
5 the process is very important because -- I've
6 found the same thing, I mean, and it's
7 documented in our report that claimants are
8 confused about what this means and -- and at
9 the end of it, remain confused and then they
10 get -- then they get angry because -- and find
11 it, you know, the interview process and the
12 whole process, meaningless. I think, you know,
13 we have -- I certainly have found the same
14 kinds of thing that Mike has found at Mound
15 echoed in other places as we've interviewed
16 people; that -- that this is -- and I think
17 NIOSH knows this, that this is a problem.

18 **MR. HINNEFELD:** Well, certainly it's -- it's
19 not new information. I mean we're not hearing
20 it here for the first time. And I think that
21 we certainly welcome suggestions to improve it.
22 I mean, we have a difficult communication path
23 -- you know, task.

24 **MR. GRIFFON:** Yeah.

25 **MR. HINNEFELD:** I think everybody will agree

1 with that. We're trying to explain a program
2 that's not very easily explained to the layman.
3 And so certainly I think in the sense that
4 these findings and the comments we hear and
5 Mike's comments and -- you know, that he
6 relates from others -- these are all important
7 information to us as we carry out our task in
8 terms of how we, you know, emphasize, you know,
9 serving the -- serving the claimant in this
10 process. The -- an added advantage of written
11 re-- findings, specifically on particular parts
12 of the procedure, is that that allows us to
13 systematically incorporate in our instructions
14 -- instructions to our staff, that these are
15 the things that need to be considered as you
16 deal with this, and these are things that we
17 want the claimant -- try to, you know --
18 attempt to -- you know, try and make the
19 claimant to understand at various places and --

20 **MR. GRIFFON:** That'll lose you a championship.

21 **MR. HINNEFELD:** I'll make my comment about that
22 later, off the record. But --

23 **MR. GRIFFON:** Please, on the record.

24 **MR. HINNEFELD:** I put the court reporter to
25 sleep.

1 The -- so I -- I certainly am not trying to say
2 that these are not -- it's not worthwhile if
3 we've not done it.

4 **MR. GRIFFON:** No, I --

5 **MR. HINNEFELD:** Quite frankly, you know, my --
6 my statement about prioritization is that
7 there's a lot of big chunks of work in front of
8 us, and this contract only has about another
9 year before their contract's over, and we have
10 a lot of big chunks of work to wrap up. And so
11 sometimes things that have a, you know -- you
12 know, actually relatively small payoff or --
13 the ORAU contract -- if they're only going to
14 interview for another year, and that's an if --

15 **MR. GRIFFON:** Yeah.

16 **MR. HINNEFELD:** -- but the current contract
17 ends in September of next year, and they have
18 all these other chunks of -- and -- and there's
19 not a big interview load in front of them, and
20 there's all these other chunks of work which
21 they have to get done in that year, this --
22 these activities, these fixes, in terms of
23 formalizing the instruction -- you know, we
24 always en-- we always verbally enforce it --
25 and -- and reinforce to our staff that you have

1 to, you know, make sure you're serving the
2 claimant in these interviews. But in terms of
3 the effort needed to formalize these
4 instructions, I've got to say, you know,
5 probably will -- has not been prioritized as
6 highly as some other items.

7 **MR. GRIFFON:** Right.

8 **DR. WADE:** Now the Board -- the working group
9 or --

10 **MR. GIBSON:** Stu, if --

11 **DR. WADE:** -- the Board can speak to that.

12 **MR. GIBSON:** -- I could just say this. Being
13 an ex-union president, I would just say that
14 hearing from these people about how they're
15 confused about the program, I seriously
16 considered resigning from the Board and going
17 to help these claimants. I mean, that's --
18 that's how serious this matter is. I -- you
19 know, if ORAU spent -- received from the
20 government I don't how many hundred thousands
21 of dollars, and people don't realize how
22 serious this is, you know -- again, I don't
23 want to see people that don't -- that didn't
24 receive exposures that caused their illness, I
25 don't want to see them receive compensation.

1 But those that did, I certainly do. And I mean
2 it's that serious to me.

3 **MR. HINNEFELD:** Well, that's a good point.
4 That's a good point.

5 **MR. GRIFFON:** As we think through this I -- I
6 mean there might be some things in here, Stu,
7 that -- that, as Mike's suggesting, are -- are
8 pretty serious priorities and maybe some that
9 are lesser, you know, because so many in--
10 interviews have been done already, maybe
11 certain procedural, you -- you know, changes
12 might not be as important, but the DR language
13 and -- and maybe OCAS form one, you know,
14 that's -- that's your interface with the public
15 and that might be more --

16 **MR. HINNEFELD:** Yeah.

17 **MR. GRIFFON:** -- a higher priority. So you
18 know, I understand what you're saying, you
19 know. You got a lot of -- a load of work
20 ahead and have to consider this in the overall
21 priorities, but --

22 **DR. WADE:** But -- but you know, the -- the
23 working group can speak to NIOSH --

24 **MR. HINNEFELD:** Yeah.

25 **DR. WADE:** -- about its priorities.

1 **MR. GRIFFON:** Right.

2 **DR. WADE:** And you know -- and -- and I'm sure
3 NIOSH will heed the working group's guidance.
4 So if, as you -- as you complete this, you
5 would like to give NIOSH some guidance on the
6 relative priority of this to other things, then
7 please do that.

8 **MR. GRIFFON:** And that's what -- we even tried
9 with OCAS-IG-1 -- we tried to --

10 **MR. HINNEFELD:** Yeah.

11 **MR. GRIFFON:** -- sort of do that with, you
12 know, this is a low priority --

13 **MR. HINNEFELD:** Yeah.

14 **MR. GRIFFON:** -- format and stuff like that --

15 **MR. HINNEFELD:** Right.

16 **MR. GRIFFON:** -- is obviously low priority, so
17 --

18 **MR. HINNEFELD:** Right.

19 **MR. GRIFFON:** -- so we could certainly attempt
20 that going forward. I -- to get back to the
21 matrix, I was wondering -- you know, I think
22 maybe if we can get back to a path forward on
23 this. Do we need to -- to put a -- an action
24 in here that NIOSH is going to revise as
25 necessary? Maybe we -- we qualify it slightly,

1 but I -- I don't know that we -- we can answer
2 all these questions today, is my point. But I
3 think I want to have an action in there that --
4 that holds it so that we move it forward and --
5 and we don't -- we --

6 **MR. HINNEFELD:** Right.

7 **MR. GRIFFON:** -- and then maybe the next
8 workgroup session we can all consider which
9 ones are high or medium or low priority amongst
10 these actions and have a more -- more --

11 **MS. MUNN:** Perhaps it's reasonable to move this
12 one up as much as the --

13 **MR. GRIFFON:** As much as I hate to move --

14 **DR. WADE:** Right, I wouldn't --

15 **MR. GRIFFON:** As much as I hate to push it
16 along again, I -- I don't think we're going to
17 resolve all these --

18 **DR. WADE:** But -- but you could take a general
19 sense -- and again, I don't want to put words
20 in your mouth, but I'm hearing a sense of the
21 working group that in all matters that -- that
22 deal with NIOSH's interaction with the claimant
23 or petitioner population, this working group
24 wants NIOSH to focus it -- focus its attention
25 in terms of the procedures comments on -- on

1 those issues, and I would think that at the
2 next meeting NIOSH can demonstrate that.

3 **MR. GRIFFON:** Right.

4 **DR. WADE:** Again, you have to talk about that,
5 but I certainly get that sense from Mike's
6 comments.

7 **MR. GRIFFON:** Yeah, I think we've -- we've
8 talked about it, you know, and --

9 **MS. MUNN:** I think that's reasonable.

10 **UNIDENTIFIED:** Yeah.

11 **MR. GRIFFON:** Yeah. Anything that -- the
12 interface with the claimants or the public is
13 certainly higher priority.

14 **MS. MUNN:** Need to move up.

15 **MR. GRIFFON:** Yeah, yeah.

16 **UNIDENTIFIED:** Mark, I --

17 **MR. PRESLEY:** Excuse me. This is Bob Presley.
18 It's not -- not just NIOSH, too. I think the
19 Department of Labor -- we've got the same
20 problem with their -- their reports.

21 **MR. GRIFFON:** Right.

22 **MR. PRESLEY:** In fact, I think that we've got
23 more of a problem with the Dep -- with the
24 stuff coming from the Department of Labor than
25 we do with NIOSH. I'm getting a whole lot more

1 complaints about -- about Labor than I am
2 anything about NIOSH.

3 **MR. GRIFFON:** And that's come to the Board's
4 attention, too, and actually Mike's raised a
5 few good points on that -- brought in sample
6 letters of that.

7 **MR. PRESLEY:** Right.

8 **MR. GRIFFON:** But what -- that's not really our
9 purview, but you know, yeah.

10 We -- can I ask -- I think you had a comment?

11 **MR. GERLACH:** Yeah. Sure.

12 **MR. GRIFFON:** Hold on, Mike, one second. We
13 got a comment from --

14 **MR. GERLACH:** Frank Gerlach. One of the things
15 I think you -- you need to do where you -- you
16 know that 60-day letter, or 60 days they have
17 to do something -- I believe they have the
18 opportunity to ask to be put on hold, and
19 they're not notified of that. I think the
20 regulations provide it, if they're actively
21 seeking some additional information that would
22 affect the -- the dose. And if you could work
23 that language into there, I think the due
24 process would be greatly helped.

25 **MR. PRESLEY:** Thank you --

1 **MR. GRIFFON:** Thank you for the comment, yeah.

2 **MS. MUNN:** That's a helpful comment. Thank
3 you.

4 **MR. PRESLEY:** -- very much.

5 **MR. GRIFFON:** Yeah. Thank you.

6 **DR. MAKHIJANI:** Mark? Maybe -- it -- it might
7 be helpful if I -- there are a few items that I
8 think, within the limitations of what Stu has
9 talked about, at least for the short term, that
10 possibly could be changed that could be of
11 great importance. At least, you know, from
12 having done -- done the review of the
13 procedures I can -- and talked to Hans and
14 Kathy who've done all these audits and looked
15 over some of their stuff -- perhaps give you a
16 little bit of a sense of the few items that I
17 think are -- are important that -- that could
18 make a material difference in terms of the
19 actual substance and -- and the public
20 confidence in this thing.

21 **MR. GRIFFON:** Yeah.

22 **DR. MAKHIJANI:** And -- and I think this
23 introductory package is really important. I
24 don't think it will take a significant change,
25 but I think what is in there and what the

1 claimant knows in the beginning before the
2 interview, what they're told -- and for the big
3 sites, to really assign the interviewers with
4 some -- with some care about what they know
5 about the site and the site profile, as -- as
6 Mike was saying -- this -- this, I think --
7 this -- this could -- maybe not a lot -- I
8 don't know how much work it takes inside ORAU,
9 but from -- from the implementability point of
10 view, that might not take very long.

11 The second item is --

12 **DR. WADE:** Just to stop you for a minute. Is -
13 - are your comments captured in the
14 acknowledgments packet? Is that what we're
15 talking about?

16 **DR. MAKHIJANI:** Yes, this first --

17 **DR. WADE:** The acknowledgment packet.

18 **DR. MAKHIJANI:** The first comment in this
19 acknowledgment package that -- and the in--
20 introductory letter and what happens in the
21 beginning of the interview -- so -- 04 and the
22 beginning of the interview process --

23 **DR. WADE:** Okay. Thank you.

24 **DR. MAKHIJANI:** Not -- not the questions that -
25 - that the public answers.

1 The second piece is the trigger for coworker
2 interviews. I think that can be -- I've
3 thought about this a lot, and I think that that
4 can be, at least as a minimal trigger, greatly
5 simplified in that for survivor claimants, or
6 for claimants who cannot answer questions
7 themselves because they are -- employee
8 claimants because they are too sick and somebo-
9 - a survivor or relative is answering for them,
10 if a claimant -- a survivor claimant is going
11 to be denied, and they have gone through the
12 trouble of naming coworkers, I think a coworker
13 interview should be mandatory and it should be
14 documented.

15 **UNIDENTIFIED:** Oh, bless you.

16 **DR. MAKHIJANI:** And it should be provided -- it
17 should be provided to the claimant, because I
18 think NIOSH has acknowledged that there is an
19 inequity -- it's manifest. You can't -- you
20 can't bring the employee back from the grave.
21 It is -- it's -- it's not an equal playing
22 field. But this one thing can be done to make
23 it less unequal and -- and I think -- and I
24 think it should -- it should be done. I don't
25 think it needs a change in the interview

1 procedure; it needs a change in the DR form,
2 that you name co -- these coworkers -- this is
3 why we didn't interview them in your case and
4 this is why -- at the time we did this review I
5 think only maybe ten or a dozen coworker
6 interviews had ever been done until Jan-- until
7 January, 2005. And -- and so the DR report
8 would need to be changed.

9 And the last big item is I do think the
10 coworker interview needs to be -- the closeout
11 interview needs to be carefully documented and
12 any information provided in the closeout
13 interview should be cross-walked with the CATI.
14 Because when -- when the -- when the person is
15 providing the inter-- interview -- in the
16 closeout interview new information about --
17 that may affect dose reconstruction, or it may
18 already have been there in the CATI and hasn't
19 been used, it's really important for the dose
20 reconstructor and for NIOSH to know that.

21 **MR. GRIFFON:** Isn't the closeout interview
22 documented already?

23 **MR. HINNEFELD:** Yeah.

24 **MR. GRIFFON:** I mean --

25 **MR. HINNEFELD:** It's -- it's -- might be

1 related to the phone log, but I mean it would
2 need -- it may need some specific assistance in
3 the, you know, the categories of things you
4 think should be documented there. Th-- they
5 are documented in the phone log.

6 **MR. GRIFFON:** Documented that you -- that you
7 had one or --

8 **DR. MAKHIJANI:** I think they're documented in
9 the sense that it happened.

10 **MR. GRIFFON:** Oh, just that it happened, or --
11 no? Notes from the call, yeah.

12 **MR. MCFEE:** No, there is extensive, extensive
13 notes from the call, generally cut and pasted
14 from Word into the phone log. We can get you
15 copies of th--

16 **DR. WADE:** Right, but Arjun's point is that it
17 needs to be scripted in a way that the -- the
18 right interactions are made --

19 **MR. HINNEFELD:** Right.

20 **DR. WADE:** -- and presented to the claimants.
21 So we -- we understand.

22 **MR. HINNEFELD:** And just in case anybody's
23 interested, if there's information presented in
24 the closeout that is different than the
25 assumptions during the dose reconstruction,

1 then the dose reconstruction is redone.

2 **MR. GRIFFON:** Yeah. Right.

3 **MR. HINNEFELD:** We have a whole loop for that.

4 **MS. MUNN:** Uh-huh.

5 **MR. GRIFFON:** Have you reviewed the -- the
6 close-- SC&A, have you guys reviewed closeout
7 interview logs?

8 **UNIDENTIFIED:** No.

9 **MR. GRIFFON:** I assume in some of the cases
10 we've looked at those -- no?

11 **UNIDENTIFIED:** (Unintelligible)

12 **MR. GRIFFON:** Because they're -- they're on the
13 -- they're on the case --

14 **MR. HINNEFELD:** They're on the phone log part.
15 They're in the AR -- in the AR for the case --

16 **MR. GRIFFON:** Right.

17 **MR. HINNEFELD:** -- and in the phone log part.

18 **MR. GRIFFON:** Right.

19 **MR. PRESLEY:** This is Bob Presley. I have a
20 question.

21 **MR. GRIFFON:** And I think that might be
22 worthwhile looking at prior to our next
23 interaction on this issue. Yeah.

24 **MR. PRESLEY:** Don't you all have a process
25 where somebody identifies a coworker, that you

1 all already go and check and see if we have
2 anything on that coworker, interviews or -- or
3 anybody that's on that coworker list has had a
4 dose review or anything like that?

5 **MR. GRIFFON:** Doesn't necessarily happen.

6 **MR. HINNEFELD:** No, it's not necessarily a
7 routine thing.

8 **MS. MUNN:** There wouldn't be a reason to do
9 that if you have information on the worker. If
10 you have the worker's record, then there's no
11 reason why you would.

12 **MR. PRESLEY:** Right, but I mean there was --

13 **MR. GRIFFON:** Well, that --

14 **MR. PRESLEY:** If they -- if they list
15 coworkers, though --

16 **MS. MUNN:** Yeah.

17 **MR. PRESLEY:** -- right up front.

18 **MS. MUNN:** So you wouldn't need that if you had
19 the worker's record.

20 **MR. HINNEFELD:** Calli-- calling a coworker -- if
21 we -- you know, the -- the --

22 **MR. GRIFFON:** Well, that -- that's why we --

23 **MR. HINNEFELD:** -- just speaking
24 hypothetically, just --

25 **MR. GRIFFON:** That's why we talked about the

1 triggers.

2 **MR. HINNEFELD:** Yeah. Just --

3 **MR. GRIFFON:** I mean you may not need it, but
4 what triggers it? What should trigger it, you
5 know.

6 **MR. HINNEFELD:** -- just talking. I'm not
7 making decisions --

8 **MR. GRIFFON:** Yeah.

9 **MR. HINNEFELD:** -- or advocating a position
10 here, but a co-- if we're going to have a
11 coworker interview, it should be for a purpose,
12 you know. We shouldn't just call them and ask
13 them the entire CATI about Joe Smith who says
14 he was your coworker. We -- we -- you know,
15 and so you -- if you're going to make that --
16 these triggers then almost have to be in what
17 circumstances will it be helpful? Now
18 certainly a survivor -- a survivor claimant is
19 at a disadvantage in term-- in terms of telling
20 what happened at the site and knowledge of the
21 site and knowledge of things exposed -- it may
22 be that, you know, we know the radionuclides
23 that were present at the site. We've
24 interviewed 500 other people, 500 energy
25 employee claimants from that site, and we have

1 information and we've captured that information
2 or through our research and it's in the site
3 profile so we know what -- what they were
4 exposed to. We may know about the site
5 practices. We may know that it was accepted
6 practice to take your badge off and -- and
7 shield it so that you didn't get timed out.
8 You know, there may be some things like that.
9 So when -- so when you start -- I'm -- I'm
10 really struggling with -- with the concept of a
11 trigger for a survival -- for a survivor
12 interview when in fact the survivor interview
13 is -- you know, it's really for a specific
14 purpose, you know. I was involved in this
15 event and so was Joe Smith and I don't think
16 it's in my record, and sure enough it's not in
17 his record, and you call Joe Smith and he says,
18 yeah, we did that and whatever ever reason they
19 don't show up on our film badge -- I mean,
20 that's -- that's a pretty extreme example, but
21 --

22 **MR. GRIFFON:** Right.

23 **MR. HINNEFELD:** -- you -- you almost have to
24 call him for a purpose --

25 **MR. GRIFFON:** Right. Oh, I agree. I agree.

1 **MR. HINNEFELD:** So when we say coworker
2 interviews should be done, it's not quite as
3 simple as saying you can have cer-- you can
4 have a threshold for a coworker interview. You
5 know, it's a little more complicated than just
6 that.

7 **MR. GRIFFON:** No, I think the trigger -- I -- I
8 didn't suggest that this trigger proc-- process
9 would be like one -- one trigger. I think
10 there's a -- you know, sort of a --

11 **MR. HINNEFELD:** Sort of a ser-- a logic
12 pathway.

13 **MR. GRIFFON:** If this -- if this/then this --
14 yeah, a logic --

15 **MR. HINNEFELD:** Sort of a logic pathway. I
16 see.

17 **MR. GRIFFON:** Right.

18 **DR. WADE:** And there's two parts --

19 **MR. GRIFFON:** That's kind of what I was
20 envisioning anyway.

21 **DR. WADE:** There's a logic pathway. But then
22 Arjun is saying, if the logic pathway takes you
23 not to conduct a coworker interview, then you
24 should present the logic for that to the
25 individual who gave you the information --

1 **MR. HINNEFELD:** Yeah. That would be the dose
2 reconstructor.

3 **DR. WADE:** -- since we didn't do that
4 (unintelligible).

5 **MR. GRIFFON:** And that would be in the DR
6 report, yeah. Yeah, we -- we -- you know, you
7 did identify individuals; however, we didn't
8 need to contact them, because --

9 **DR. MAURO:** The difficulty with -- and -- and
10 certainly that makes sense, but I think that
11 the last time we discussed this, the reason the
12 coworker interviews were not as prevalent as
13 your -- it was because you didn't --

14 **MR. GRIFFON:** Maximizing.

15 **DR. MAURO:** -- the maximizing approach, and I -
16 - and I have to say, it's going to be one
17 difficult time to try to explain -- in other
18 words, as though -- as you had just mentioned -
19 - well, the reason we didn't follow up on your
20 recommended coworkers is because we used this
21 maximizing approach which uses these 12
22 radionucli-- you know, and -- and then you're
23 down into this position where you -- where it's
24 going to get worse. It's not going to get
25 better. So it's almost as if we've got

1 ourselves --

2 **MR. GRIFFON:** I hate to give up before we try.

3 **DR. MAURO:** -- an un-- un-- yeah. Yeah.

4 Right. Now -- but then -- then there's, so --
5 from the point of view of the -- there's the
6 other side of the questions. Do you perform a
7 coworker interview? Do you open up a dialogue
8 because you're more concerned with a bedside
9 manner issue; that is, you're trying to create
10 peace of mind. What I'm hearing is really that
11 your -- your objective is to get factual
12 information that's going to allow you to do the
13 best job you possibly can do in your dose
14 reconstruction --

15 **MR. GRIFFON:** That's the way we've behaved
16 (unintelligible).

17 **DR. MAURO:** -- and that's the way it's been
18 designed, and I can understand that. But what
19 I'm hearing at the same time is that one of the
20 unanticipated consequences of going down that
21 path is the cre-- is the creation of some
22 degree of alienation, because that process does
23 not always lend itself to developing confidence
24 and a -- and a sense, you know, that yes, I am
25 being treated as a human being, I -- there's

1 someone out there who cares about it. So I
2 think that we have thi-- a situation that is --
3 perhaps we -- we could strike a balance
4 someplace where we optimize, but I do think we
5 have conflicting objectives that are not easily
6 resolved entirely. Certainly we have to get
7 the information we need to do the dose
8 reconstruction, but unfortunately, I think, to
9 date, in so doing I think it's possible that
10 the bedside manner side of the equation --

11 **MR. GRIFFON:** I --

12 **DR. MAURO:** -- has been -- has not been tended
13 to.

14 **MR. GRIFFON:** I don't think they're
15 incongruous, if that's the right word.

16 **DR. MAURO:** Yeah, yeah. Okay.

17 **MR. GRIFFON:** I mean I -- I think that -- you
18 know, from the claimant's standpoint, they want
19 to know that you've considered their specific
20 information. But if you didn't -- if you had
21 no reason, I think they wou-- and -- but it's
22 not in the report right now, or -- or it wasn't
23 in the older reports --

24 **MR. HINNEFELD:** No, it's not.

25 **MR. GRIFFON:** -- an explanation that, you know,

1 you provided all these specifics, but here's
2 why we didn't need to go down that path with
3 your particular case. We had your specific
4 dosimetry; we had -- you know --

5 **MR. HINNEFELD:** Yeah. We -- we don't --

6 **MR. GRIFFON:** I -- I think --

7 **MR. HINNEFELD:** -- comment on coworker.

8 **MR. GRIFFON:** -- with thi-- this maximizing
9 issue it does get -- it can get complicated --

10 **DR. MAURO:** Yeah.

11 **MR. GRIFFON:** -- but I think it can be done and
12 I don't think that they would -- you know, I
13 don't think that we should -- I -- I -- at
14 least personally, I don't feel that we should
15 ask the program to interview coworkers just for
16 the sake of being able to say to the claimant
17 that yeah, we checked with these coworkers and
18 we verified that you worked at K-25, you know?
19 It had nothing to do with your dose
20 reconstruction report, but there you go.

21 **DR. MAURO:** We did it any-- we did it anyway.

22 **MR. GRIFFON:** You know, isn't that good bedside
23 manner. I mean that's --

24 **DR. MAURO:** I -- I understand, yeah.

25 **MR. GRIFFON:** I mean I -- I don't think that's

1 useful at all.

2 **MS. MUNN:** No, and as a matter of fact, there
3 are even privacy issues that are involved
4 there, that --

5 **MR. GRIFFON:** Right, right.

6 **MS. MUNN:** -- you don't want to get into that
7 --

8 **MR. GRIFFON:** I just think -- I -- I -- don't
9 think that --

10 **MS. MUNN:** -- unless you have to.

11 **MR. GRIFFON:** I think Stu's stated policy is
12 good, that -- that you do it when you need to
13 do it for the purposes of the individual dose
14 reconstruction. Now the -- the question is,
15 with survivors, I think you -- you get into the
16 question of do you know enough about that
17 person's job history, because you're not --
18 Arjun's point is that when you're interviewing
19 the survivor they're likely not to know much
20 about that person's job history. And then,
21 you know, is there a different trigger on those
22 survivor claims that says, you know, geez, we
23 have sketch-- real sketchy dosimetry
24 information on this person --

25 **MR. GIBSON:** This -- this is Mike --

1 **MR. GRIFFON:** -- all we know about them is that
2 they worked at that plant. Maybe we need to
3 interview a coworker and find out more about
4 what -- what this individual did, you know? Go
5 ahead, Mike.

6 **MR. GIBSON:** I just want to make sure that
7 we're not getting confused here and -- and, you
8 know, -- I know I've got us off subject, but I
9 originally started talking about living
10 claimants that have a potential case that don't
11 understand the process, not necessarily the
12 coworkers or their survivors -- which are
13 important, but I'm -- I was just talking about
14 claimants themselves that don't understand this
15 process.

16 And secondly, I just -- you know, I want to
17 agree with Mr. Presley that, you know, I'm not
18 criticizing NIOSH. It's DOL, it's the whole
19 structure of the process that has had -- that
20 has claimants confused and giving up when, you
21 know, they may or may not have a legitimate
22 case to file.

23 **MR. GRIFFON:** No, we -- we got that point,
24 Mike. I guess we were going down that path
25 because Arjun was going down some specific

1 recommendations on ways to modify some of these
2 procedures. And that's why we got into the
3 coworker question.

4 **MR. HINNEFELD:** Yeah.

5 **MR. GIBSON:** Okay.

6 **DR. MAKHIJANI:** Well, some -- some -- sorry,
7 Mike. Go ahe--

8 **MR. GIBSON:** No. No, I'm done.

9 **DR. MAKHIJANI:** In regard to -- in regard to
10 the specific case of survivor claimants who are
11 going to be denied, let me just kind of --
12 because I have thought about this a lot. The
13 -- they cannot talk about incidents. Generally
14 they don't know about radionuclides. Very
15 often they don't know about processes. So you
16 -- you read the interview forms and most of it
17 is "don't know," even though the interview form
18 is minimal compared to the employee interview
19 form. I think in that -- unless you have an
20 extraordinarily complete record for this record
21 for this worker, you don't know that they
22 haven't been involved in spills, 'specially
23 when you've got workers from the 40's, 50's and
24 60's, when the documentation on-site is -- we
25 know is more sparse than in later times.

1 You've -- you've got a situation where I feel
2 you cannot be confident, as a dose
3 reconstructor, that when you apply the 12 or
4 the high five, that you're actually doing a
5 good dose reconstruction. You don't know that.
6 We -- we --

7 **UNIDENTIFIED:** Question.

8 **DR. MAKHIJANI:** -- we saw that at Mallinckrodt,
9 that I -- I personally have looked at cases
10 where the 12 from Hanford were applied to
11 Mallinckrodt cases, and when we actually got
12 into the details of the actiniums and the
13 protactiniums, I felt -- and we did write in
14 the report -- that if you go back and redo
15 those things, you may actually find a higher
16 dose than what NIOSH was confident could not be
17 exceeded under a maximum dose reconstruction.
18 And I think if there is not -- if there's not
19 some kind of -- when the -- when the survivor
20 has gone through the trouble of finding a
21 coworker, if there's not an interview process
22 that -- that -- by which NIOSH can be sure that
23 -- that they haven't -- otherwise, NIOSH has to
24 certify that this is a complete dose
25 reconstruction file and we have not -- we don't

1 see the need for a coworker interview because
2 we've got every film badge record and we know
3 that there were no incidents in which this
4 worker was involved -- which are not documented
5 -- I think that is a very, very high bar from
6 whatever I know about the program.

7 **MR. GRIFFON:** I -- I still think this falls
8 into that whole logic tree of triggers that I
9 was, you know, sort of -- from an action
10 standpoint, I think it's -- it kind of falls
11 under that category. But I -- I mean to -- to
12 be -- I -- I hear your point, Arjun, but I'm
13 wondering if -- trying to think of some of the
14 AWE site where you would say that for all
15 workers we're applying this model and -- I
16 think this is a big and -- but it's -- and they
17 -- they -- on-line training?

18 **UNIDENTIFIED:** Yep.

19 **MR. GRIFFON:** And -- and there's -- in the --
20 in your process of doing the Bethlehem Steel
21 you've interviewed 20 or so workers at the site
22 and therefore, you know -- so in that case do
23 you still think each survivor should have a
24 coworker interview done if they've identified a
25 coworker? I'm just -- just probing you on this

1 point a little bit, I guess.

2 **DR. MAKHIJANI:** Yeah. I -- I'm not sure.

3 **MR. GRIFFON:** Yeah.

4 **DR. MAKHIJANI:** I mean Bethlehem Steel is a
5 kind of very stripped down case where there's -
6 -

7 **MR. GRIFFON:** But there's a lot of those AWEs
8 that fall into that category, that's why I ask.
9 Yeah.

10 **DR. MAKHIJANI:** Yes. Yeah. Yes, that's true.

11 **MR. GRIFFON:** So maybe not for every co-- you
12 know.

13 **DR. MAKHIJANI:** Yeah. Let --

14 **MR. GRIFFON:** So let's ask for some kind of
15 logic to that trigger, I think, is what we're -
16 -

17 **DR. MAKHIJANI:** -- let me just say that if --
18 at the -- at the end of the day, there is a
19 subst-- it's not a bedside manner question, in
20 my mind.

21 **MR. GRIFFON:** Right.

22 **DR. MAKHIJANI:** There's a substance issue
23 involved. And before you get to get to the
24 convincing the survivor, I think the substance
25 issue's got to be settled. At the end of the

1 day, is NIOSH sure that it has sufficient
2 information that the number that it has --
3 either on a best case or a maximum case -- is
4 truly what has been promised in the regulation
5 and the law. And I'm not confident that
6 currently that -- that is always the case, and
7 I've given you a specific example of that.

8 **MR. GRIFFON:** Yeah. Right. Okay.

9 **DR. MAKHIJANI:** The -- even in the maximum
10 case. Once that is done, then you can
11 represent that. So this -- this coworker
12 interview process has to be -- so, okay, you've
13 interviewed 20 workers and you've got the
14 rolling part of it, and you've got the cooling
15 bed part of it, and the shearing part of it,
16 and you've got the cobbling part of it; okay.
17 So you -- you've -- we've done that actually
18 for Bethlehem Steel. We've got all of these
19 interviews and I think that that can be
20 explained, that your husband or your father
21 worked at the rollers, and we have that --

22 **MR. GRIFFON:** And we've interviewed some people
23 that -- yeah.

24 **DR. MAKHIJANI:** -- and we have these interviews
25 --

1 **MR. GRIFFON:** Interviewed coworkers.

2 **DR. MAKHIJANI:** -- that fulfill the same
3 function --

4 **MR. GRIFFON:** Right.

5 **DR. MAKHIJANI:** -- as the person whose name you
6 gave us. And I don't think -- I don't think a
7 person at the other end would take it amiss
8 that that -- you know, Joe Smith wasn't called,
9 but --

10 **MR. GRIFFON:** That's the only reason I pointed
11 that out --

12 **DR. MAKHIJANI:** Yeah, no, I think that's right.

13 **MR. GRIFFON:** -- because it could be -- yeah.
14 Yeah.

15 **DR. MAKHIJANI:** But some-- someth--

16 **MR. GRIFFON:** So I think still the action is
17 probably that this coworker trigger question
18 that you might consider -- and it's clearly a
19 sort of logic tree approach, I guess.

20 **MR. HINNEFELD:** Yeah. I -- I can just -- it
21 just seems problematic to me, but I mean I'm
22 not saying it can't be done. But I'm saying it
23 will be difficult to come up with a logic path
24 that -- in -- in a lot of cases. But maybe
25 not. Maybe -- maybe I'm just being

1 pessimistic.

2 **MR. GRIFFON:** I mean you -- you have any
3 problems right now that you want to identify or
4 you want to just think on it and report back?

5 **MR. HINNEFELD:** No, it's -- it's more of --

6 **MR. GRIFFON:** Yeah.

7 **MR. HINNEFELD:** -- more of a gut feeling. I'm
8 try-- well, if we're going to ask -- you know,
9 I -- I would guess since we will have a
10 particular set of things to ask a coworker,
11 because you really -- I mean, you'd call for a
12 reason, you're essentially then customizing
13 each one, you know -- or maybe not. May-- if
14 you have -- if it's not a custom interv-- if it
15 is -- if it's not a custom interview, if it's a
16 standard interview, then -- and we ask more
17 than nine, then we have to have an OMB approval
18 on a coworker interfor-- interview form. If,
19 you know, there are --

20 **MR. GRIFFON:** You've got coworker interviews
21 now, to date, haven't you?

22 **MR. HINNEFELD:** Yeah, but you know, they were
23 in a sense a -- custom coworker interviews, you
24 know, for a particular issue.

25 **MR. GRIFFON:** Right. But how would that be --

1 I don't think we're asking for a different --
2 **MR. HINNEFELD:** So you're asking -- but these
3 are custom, and you're asking for a custom
4 interview --

5 **MR. GRIFFON:** Yeah.

6 **MR. HINNEFELD:** -- on every survivor claim,
7 which is half the claims.

8 **MR. GRIFFON:** And they only -- and -- and they
9 only would be done for the purposes of
10 answering a question, as -- as you --

11 **MR. HINNEFELD:** Right.

12 **MR. GRIFFON:** -- I don't think it's different
13 than your stated policy.

14 **MR. HINNEFELD:** I'm just -- I'm just --

15 **MR. GRIFFON:** Right.

16 **MR. HINNEFELD:** I'm struggling with it, will we
17 find all the triggers. You know, will we --
18 will have a --

19 **MR. GRIFFON:** I agree.

20 **MR. HINNEFELD:** -- coherent --

21 **MR. GRIFFON:** I mean I'm just thinking --

22 **MR. HINNEFELD:** -- ahead of time.

23 **MR. GRIFFON:** Right.

24 **MR. HINNEFELD:** Will we be able to foresee the
25 -- the things that are going to say well, maybe

1 this sh--

2 **MR. GRIFFON:** I agree.

3 **MR. HINNEFELD:** -- should be done in this case.
4 And then -- and again, there -- and, as you've
5 alluded to, there are a lot of cases that, on
6 the face of them, are not going to be
7 successful and we just aren't going to be able
8 to make them successful. People who have short
9 employment periods, short or a non-ex-- or
10 almost non-existent latency periods, and cer --
11 and a -- and a radiation-resistant cancer, you
12 can't find out enough stuff to make that case
13 compensable.

14 **MR. GRIFFON:** Right, right.

15 **MR. HINNEFELD:** And so there are certain cases
16 where it kind of drops off. I -- I'm sorry, it
17 just does.

18 **DR. MAKHIJANI:** Well, I -- I think that that --
19 you know, this information is held in a kind of
20 a closed way by the cognoscenti of the program.
21 All of us who do numbers and sit in meetings
22 know that prostate cancers almost never get
23 compensated. And you know, I've broached this
24 subject in -- in private with -- with some of
25 the people --

1 **MR. HINNEFELD:** Yeah.

2 **DR. MAKHIJANI:** -- that I think that the public
3 ought to know that, that prostate cancers, from
4 the way the law is written, and -- and Dr. Wade
5 testified to this -- to this effect -- that,
6 you know, many people get denied, not -- not
7 because NIOSH is-- isn't good -- doing a good
8 job, it's from the way the law is written; that
9 if you have to have a 50 percent or more PC and
10 given the nature of the best we know about
11 radiation, prostate cancers are almost never
12 going to be compensated.

13 **MR. HINNEFELD:** Right.

14 **DR. MAKHIJANI:** And I think this is a simple
15 truth that the public does not know. And --

16 **MS. MUNN:** But if you're going to give that
17 truth, then you need to also give the truth of
18 what the actual epidemiological evidence is.
19 And I know everybody fights that. No, no, this
20 is not an epidemiological study. I know it's
21 not a study, but the truth is, if -- and I'm
22 unsure of what the exact percentage is, but my
23 memory is that it's well over 60 percent of all
24 males over the age of 60 have some form of
25 prostate cancer.

1 **MR. SHARFI:** Proportional to your age.

2 **MS. MUNN:** Yeah. And -- and if that's the
3 case, then if we're going to on the one hand
4 say we can't provide you compensation for this
5 because the law says this, then we must also on
6 the other hand, to be fair, say however, in
7 point of fact, the reality is, you probably --
8 given the statistical realities that exist in
9 the world today, you can't -- there's no way
10 that one can say your employment had anything
11 to do with this.

12 **MR. GRIFFON:** Well, I guess you read further in
13 tha-- into that than I did, but I -- I mean --
14 just to say we can't because of the law, I -- I
15 guess I see your point. I mean --

16 **MS. MUNN:** That's not what I --

17 **MR. GRIFFON:** I don't think the law -- I don't
18 think the law's wrong in that, you know.

19 **MS. MUNN:** No, but -- but --

20 **DR. MAKHIJANI:** No.

21 **MR. GRIFFON:** I mean prostate cancers probably
22 should not be 'cause they're less radio-
23 sensitive. At least the evidence is --

24 **DR. MAKHIJANI:** Yes.

25 **MR. GRIFFON:** -- to date, says that, so --

1 **DR. MAKHIJANI:** If there's a probability of
2 causation test --

3 **MR. GRIFFON:** Right.

4 **DR. MAKHIJANI:** -- and this is -- so this is
5 sort of outside of our purview -- so long as
6 that test is there, then it is from the -- it
7 is from the general occurrence of prostate
8 cancer that that probability of cancer is so
9 difficult --

10 **MR. GRIFFON:** Yeah.

11 **DR. BEHLING:** -- to exceed 50 percent. So
12 actually, what you're saying complements -- is
13 -- it isn't opposed --

14 **MR. GRIFFON:** Right.

15 **DR. MAKHIJANI:** -- to what I was saying or
16 what's in the law.

17 **MR. GRIFFON:** And I -- I agree with Stu. I
18 think you need -- I mean, I think we need to
19 consider this moving forward, if -- if a
20 trigger can work, or what -- what type of logic
21 can be consi--

22 **MR. HINNEFELD:** We can -- we can certainly take
23 a look at it.

24 **MR. GRIFFON:** -- because I can see some
25 pitfalls in --

1 **MR. HINNEFELD:** I mean, I'm not saying we're
2 not going to do it -- I'm just, I'm -- maybe
3 I'm just a pessimist --

4 **MR. GRIFFON:** I mean I'm not sure how -- how
5 exactly the program uses POC triggers, either,
6 'cause I think that's a dicey little area --
7 because NIOSH is not in the business of
8 estimating P-- or calculating POCs. Right?
9 That's DOL.

10 **MR. HINNEFELD:** DOL makes the determination of
11 POC but we certainly --

12 **MR. GRIFFON:** Right. So how you screen on POC,
13 and --

14 **MR. HINNEFELD:** Well, we--

15 **MR. GRIFFON:** -- how you write that up in your
16 procedure, I think --

17 **MR. HINNEFELD:** Well, I mean --

18 **MR. GRIFFON:** -- if -- if you include that --
19 go ahead.

20 **MR. HINNEFELD:** It's in -- it's in, kind of,
21 Procedure 6 and --

22 **MR. GRIFFON:** Oh, it is. Okay.

23 **MR. HINNEFELD:** There is a categorization --
24 yeah, we do it.

25 **MR. GRIFFON:** Okay.

1 **MR. HINNEFELD:** You know -- and do it from
2 accumulated knowledge of whether a case is --

3 **MR. GRIFFON:** Right.

4 **MR. HINNEFELD:** -- this looks like this is
5 almost surely a pay-- I mean there's plenty of
6 case -- long -- long exposure to actinides in a
7 lung cancer --

8 **MR. GRIFFON:** Yeah.

9 **MR. HINNEFELD:** -- you know, that's -- that's
10 going to be easy; short -- short exposure and
11 -- or -- short --

12 **MR. GRIFFON:** So, I agree, I mean -- I agree
13 with --

14 **MR. HINNEFELD:** -- short latency period and
15 most solid tumors, that's -- or -- you know, or
16 not -- not metabolic type of tumors are not
17 going to be, you know --

18 **MR. GRIFFON:** My sense -- my sense is that in
19 writing a logic pattern for the triggers, I
20 think you're right -- we're not going to --

21 **MR. HINNEFELD:** I don't think we're going to
22 foresee everything.

23 **MR. GRIFFON:** Up front -- up front you're
24 probably not going to foresee everything,
25 right. I mean you're not going to get all the

1 what-ifs. I mean, the AWE one that I just
2 brought up, I think there's good rationale for
3 -- for probably not interviewing all coworkers
4 from survivors because you've already
5 interviewed a bunch for Bethlehem, you know.
6 That's one example. And then -- but you're not
7 going to foresee all the -- you know, but --

8 **DR. WADE:** But the fact that you're not going
9 to foresee them all is -- is not a reason to
10 not strive.

11 **MR. GRIFFON:** Doesn't mean you can't --

12 **MR. HINNEFELD:** -- to not try. Right.

13 **MR. GRIFFON:** Exactly. Exactly. That's my
14 point.

15 **DR. WADE:** The instruction is clear that the
16 working group would like to see NIOSH explore
17 this issue of triggers that would require that
18 we follow up on coworker interviews.

19 **MR. GRIFFON:** Right.

20 **DR. WADE:** And in the case of survivors, we
21 expect that to be much more of a hair trigger.
22 We expect that -- the test to be --

23 **MR. HINNEFELD:** Easier on a survivor claimant.

24 **MR. GRIFFON:** Right.

25 **MR. PRESLEY:** Yeah.

1 **MR. GRIFFON:** Right.

2 **DR. MAKHIJANI:** And that's what -- and NIOSH
3 needs to come back to the working group and say
4 here is our thought on this, and then the
5 working group can --

6 **MR. GRIFFON:** Now -- now, generally -- again, I
7 don't want to cut Arjun off, but generally what
8 I've done with the action here is to say that
9 in most of these -- and I'll re-send my matrix
10 one more time on this -- but most of them are
11 now going to say NIOSH will modify procedures
12 and policies as appropriate. SC&A will review.
13 The trigger one I'm going to -- some of the
14 specific ones we had in there, I'll leave those
15 as -- as written before. But some of the ones
16 that before just said, for instance, for SC&A
17 to review Proc 90 and 92, I think we've
18 realized that -- that wasn't really
19 appropriate.

20 **MR. HINNEFELD:** Right.

21 **MR. GRIFFON:** So I'm -- I'm replacing it with
22 just kind of a "NIOSH will modify procedures
23 and policies as appropriate" -- that qualifies
24 it big time --

25 **MR. HINNEFELD:** Right.

1 **MR. GRIFFON:** -- "and SC&A will review" -- and
2 we'll move this forward, you know --

3 **MR. HINNEFELD:** Yeah, and --

4 **MR. GRIFFON:** -- 'cause my intent is to close
5 this --

6 **MR. HINNEFELD:** Right.

7 **MR. GRIFFON:** -- procedures review out. I mean
8 we really need to --

9 **MR. HINNEFELD:** This would be -- right --

10 **MR. GRIFFON:** -- to move on to the procedures
11 that are being used in the program.

12 **MR. HINNEFELD:** This would be a step after --
13 after CATI. You were saying -- I like what you
14 said, "modify procedures and -- and policies"
15 because -- we don't want to specify which one
16 because it may be something we write --

17 **MR. GRIFFON:** Right.

18 **MR. HINNEFELD:** -- that occurs after the CATI
19 step.

20 **MR. GRIFFON:** Right.

21 **MR. HINNEFELD:** You know, realistically, that's
22 where it would occur --

23 **MR. GRIFFON:** Yeah.

24 **MR. HINNEFELD:** -- is after the CATI step where
25 you'd run through these triggers--

1 **MR. GRIFFON:** So --

2 **MR. HINNEFELD:** -- to determine whether to do a
3 coworker interview.

4 **MR. GRIFFON:** Is that okay? And then -- go
5 ahead.

6 **MS. MUNN:** We have to be realistic. You know,
7 as much as we would like to mechanize
8 everything that we do and say here's the jump-
9 off point, here's where you do this, here's
10 where you don't do this, this alone tells us
11 how impossible that is. We -- you know --

12 **MR. GRIFFON:** Well, yeah. And the other -- the
13 --

14 **MS. MUNN:** -- we're making -- we're doing our
15 best to try to do that.

16 **MR. GRIFFON:** I agree. I agree.

17 **MS. MUNN:** But in point of fact, what it
18 comes down to is everyone involved in this
19 process at some juncture has to use their best
20 technical judgment.

21 **MR. GRIFFON:** Well, and there's -- there's ways
22 to -- I just -- I'm glad you brought up that
23 point, 'cause there's way -- in those triggers,
24 I think there's ways procedurally -- and you
25 guys do this for a living more than I do, but I

1 mean the -- the -- or the DR or -- can be
2 shall, should, and may, you know? I mean you
3 can have different levels of -- so it's --

4 **MR. HINNEFELD:** Right.

5 **MR. GRIFFON:** -- it's a little fuzzier. I mean
6 I, you know -- we don't -- we -- you know,
7 'cause -- 'cause of just the situations that
8 Stu is describing, I think we're not going to
9 foresee everything so we may have to, you know,
10 certainly consider some softer language in
11 those triggers that, you know -- but you know,
12 I think we need to at least attempt that and
13 move forward with that. And as -- as Lew said,
14 probably a -- more of a hair trigger with the
15 survivors.

16 **MS. MUNN:** Right.

17 **MR. GRIFFON:** More of a hair trigger. Arjun,
18 did you have other sp-- specifics that we --

19 **DR. MAKHIJANI:** No, I think --

20 **MR. GRIFFON:** Because I think we're almost --

21 **DR. MAKHIJANI:** Yeah, I think I've mentioned
22 the most important things --

23 **MR. GRIFFON:** Right.

24 **DR. MAKHIJANI:** -- from -- from the review.

25 The -- the four things. And I think the rest

1 is detail -- either detail or would require
2 modification of the CATI form, which -- I don't
3 know how you want to proceed with that.

4 **MR. GRIFFON:** Well, we still have the -- we
5 still have that in there as a recommendation --
6 "NIOSH to consider the -- the modification of
7 the for--," the CATI questionnaire itself.
8 Right?

9 **MR. HINNEFELD:** It -- it's in there, and --

10 **MR. GRIFFON:** Yeah.

11 **MR. HINNEFELD:** -- and it's something that we
12 might -- you know, we can do.

13 **MR. GRIFFON:** We can carry tha-- as much as I
14 didn't like the fuzzy language, I think we can
15 carry that forward to consider.

16 **MR. HINNEFELD:** I wouldn't -- I would like
17 perhaps a little instruction. I don't know if
18 we can get this today, but maybe from the
19 workgroup or SC&A, we were given an example of
20 a preferable interview that was the Y-12
21 berylliosis or beryllium interview. And -- and
22 I'm puzzled by the -- the more desirable
23 features. You know, why -- what about that
24 form -- I -- I've read -- I've read the
25 questionnaire.

1 **MR. GRIFFON:** Yeah.

2 **MR. HINNEFELD:** What about that questionnaire
3 is better than the CATI questionnaire? You
4 know, what is it that -- and I'm just not a --
5 maybe I'm just not an interview person, but I --
6 - I read it, and it looked a lot like the CATI
7 interview to me, except of course it was
8 specific to Y-12. And it could be a lot -- you
9 know, it could have details about what
10 buildings you were in and stuff --

11 **MR. GRIFFON:** Right.

12 **MR. HINNEFELD:** -- 'cause it was specific to Y-
13 12. But I -- I didn't -- other than that, I
14 didn't see the advantage. And I got -- I
15 brought some examples, if anybody wants to take
16 it with them and let me know what the ad--
17 advantage of that interview is over a CATI.

18 **MR. GRIFFON:** Yeah, maybe if you have the
19 examples, yeah.

20 **MR. HINNEFELD:** And in fact, the dose
21 reconstruction -- our -- our--

22 **MR. GRIFFON:** You can share those with us and
23 we can consider it at the next meeting, but...

24 **MR. HINNEFELD:** -- our Task IV and our do-- you
25 know, work with the communicators, and the --

1 now I'm losing everything --

2 **MS. MUNN:** I didn't take it, I swear.

3 **MR. HINNEFELD:** -- the communicators and the
4 dose reconstructors probably have some ideas
5 about things that might be worthwhile to ask in
6 a CAT-- or maybe there are some things in the
7 CATI now that really don't ever yield any
8 benefit.

9 **MR. GRIFFON:** So maybe we can -- we'll carry
10 that action -- we'll carry that action forward,
11 and when we have it on the next time we'll get
12 some of the people that are doing it in the
13 room with us and we can discuss that
14 specifically. Right? Arjun?

15 **DR. MAKHIJANI:** In regard to the -- in regard
16 to the Y-12 beryllium interview, this is
17 something that I'd like Kathy DeMers to address
18 because she had a lot of experience with that
19 and we -- as you know, we did this -- this
20 piece of the Task II report together, and I
21 think one of the things, for example, was she
22 was saying, you know, when you interview
23 somebody in person it makes a lot of
24 difference. And we realize it was a telephone
25 interview --

1 **MR. HINNEFELD:** Sure.

2 **DR. MAKHIJANI:** -- and I think they did in-
3 person interviews and they had a little bit
4 more free form. Fro-- from the -- from my own
5 review of the CATI, which -- which was in a --
6 in a different realm rather than the process,
7 it -- it related to the substance of things
8 that are not in there, which are on page 205 --

9 **MR. HINNEFELD:** Right.

10 **DR. MAKHIJANI:** -- of our Task III report.

11 **MR. HINNEFELD:** And -- and I believe what we
12 said in our response was sounds like there's
13 some pretty good suggestions here; we ought to
14 take this back and evaluate, you know, if we
15 want to do this.

16 **DR. MAKHIJANI:** So -- so those -- I would
17 suggest sort of a two-track resolution of that,
18 whether the -- about what to do with the CATI
19 form.

20 **MR. HINNEFELD:** Uh-huh.

21 **DR. MAKHIJANI:** One is let me consult with --
22 with Kath-- Kathy and have either her or me get
23 back to you about this particular form and --

24 **MR. GRIFFON:** Yeah, just --

25 **DR. MAKHIJANI:** -- so she can explain to you

1 her view of this.

2 **MR. HINNEFELD:** Yeah, what's the aspect of this
3 that's better than the CATI interview --

4 **DR. MAKHIJANI:** Yeah.

5 **MR. HINNEFELD:** -- 'cause I'm -- maybe I'm just
6 not a very good interviewer --

7 **DR. MAKHIJANI:** I -- I don't recall -- I don't
8 recall our discussion from about two years ago
9 about -- about this thing so I want -- so I
10 want her to tell you, but there is this sort of
11 very specific item, no question about food, no
12 question about overtime.

13 **MR. HINNEFELD:** Right.

14 **DR. MAKHIJANI:** I mean if these could be
15 thought about --

16 **MR. HINNEFELD:** Right.

17 **DR. MAKHIJANI:** -- in terms of expanding the
18 CATI form -- modifying it.

19 **MR. GRIFFON:** And there are -- it's quite a bit
20 of experience from the medical surveillance
21 programs, too, and every program has their
22 different questionnaires.

23 **MR. HINNEFELD:** Yeah.

24 **MR. GRIFFON:** You know, some are probably
25 consistent with what you have; some might be

1 different. But I mean -- you know, my
2 experience in that program is that I get more
3 valuable information with regard to work
4 practices and/or buildings and operations and
5 processes than radionuclide or chemical
6 checklists, you know.

7 **MR. HINNEFELD:** Yeah.

8 **MR. GRIFFON:** It's difficult--

9 **MR. HINNEFELD:** Yeah.

10 **MR. GRIFFON:** -- but anyway, the --

11 **MR. HINNEFELD:** Yeah.

12 **MR. GRIFFON:** -- we can continue on that path
13 and SC&A will share their information with you
14 --

15 **MR. HINNEFELD:** Okay.

16 **MR. GRIFFON:** -- and go forward.

17 **DR. WADE:** The only procedural thing is we need
18 to break for lunch by 12:30.

19 **MR. GRIFFON:** Yeah, I was going to say 12:30.
20 I think we need to take five in a few minutes.

21 **DR. WADE:** Right. They're going to shift --
22 they're going to shift rooms when we break.
23 There's been a confusion in terms of the rooms,
24 but we just move down two doors. But if we do
25 that by 12:30, we're fine.

1 **MR. GRIFFON:** All right. Are we -- did we
2 cover everything in these -- so -- so I'll --
3 I'll send the new matrix, but a lot of these
4 items now are going to have that -- that NIOSH
5 will recons-- or will consider the policy and
6 procedures and SC&A will review them, so we're
7 going to sort of carry this task -- or this
8 review forward and not jump off into 90 and 92.
9 It doesn't make sense.

10 **DR. MAURO:** No. We'll -- we'll pull the plug
11 on that.

12 **MR. GRIFFON:** We'll stick with these specific
13 issues, yeah. Yeah.

14 **MR. HINNEFELD:** Yeah.

15 **DR. MAURO:** We're pulling the plug on 90 and 92
16 for the time being.

17 **MR. GRIFFON:** Yeah.

18 **DR. MAURO:** Okay. Good.

19 **MR. GRIFFON:** All right?

20 **DR. WADE:** Just for my general information,
21 this acknowledgment pack and a revised
22 attachment to CATI letter, has that -- are we
23 in the process of reviewing what NIOSH has
24 prepared?

25 **MR. HINNEFELD:** We're -- we're --

1 **DR. WADE:** Or is it not prepared?

2 **MR. HINNEFELD:** It's not prepared.

3 **MR. GRIFFON:** No. It's not final.

4 **MR. HINNEFELD:** It's a product that's not --
5 not -- we're not ready to share it with the
6 Board. I mean -- it -- we'll share it with the
7 Board --

8 **MR. GRIFFON:** But when it is --

9 **MR. HINNEFELD:** -- when it's absolutely final,
10 but we want to have a product we're happy with.

11 **DR. WADE:** When it is, you'll share it with
12 SC&A so that's--

13 **MR. HINNEFELD:** And if the -- see, that was the
14 acknowledgment packet -- and the attachment to
15 the CATI letter is -- has been done. That was
16 -- that issue had to do with -- there was sort
17 of some coercive language on -- this was the
18 CATI introduction letter. You know, we --
19 we're going to interview you, and there was an
20 attachment on there that kind of said that
21 you'd better interview, you know, it's really
22 important, et cetera, et cetera -- and so it
23 kind of set in mind -- and this was part of the
24 findings in the bulk of the report -- you won't
25 find it on the matrix, but in the bulk of the

1 report, was this is kind of a scary -- you
2 know, you really are --

3 **MR. GRIFFON:** Right.

4 **MR. HINNEFELD:** -- setting these people up and
5 putting them in a bad situation. Now that
6 attachment has been changed.

7 **DR. WADE:** Okay.

8 **MR. HINNEFELD:** And I prob-- I believe I
9 provided copies of the -- the new and the old,
10 but I can.

11 **MR. GRIFFON:** I don't know if I've captured
12 that on the matrix, but we should probably add
13 that on, that the attachment gets --

14 **DR. MAKHIJANI:** I think it is in the matrix.

15 **MR. GRIFFON:** -- gets reviewed again.

16 **DR. MAKHIJANI:** It is in the matrix that it has
17 been changed.

18 **MR. HINNEFELD:** Yeah, it has -- we have changed
19 it.

20 **MR. GRIFFON:** But -- but not that SC&A is
21 reviewing it.

22 **DR. MAKHIJANI:** No. We have -- I have not seen
23 it. Maybe I lost it in the whole report.

24 **MR. GRIFFON:** I'll -- I'll carry it through,
25 but that will be an SC&A action.

1 **MR. HINNEFELD:** Yeah, I'll e-mail you a copy of
2 both.

3 **DR. MAKHIJANI:** Okay, great.

4 **MR. GRIFFON:** I think if we can take five, I
5 think some people might have to check out of
6 the hotel. Let's take a short break and then
7 we'll still plan on breaking for lunch at
8 12:30, but we'll start the second set of cases
9 when we get back.

10 **MS. MUNN:** Did I hear Lew say we had to move
11 rooms?

12 **MR. HINNEFELD:** Yeah, after the lunch break.

13 **MR. GRIFFON:** After the lunch break at 12:30
14 we'll have to move rooms.

15 **MS. MUNN:** Well...

16 (Whereupon, a recess was taken from 11:25 a.m.
17 to 11:40 a.m.)

18 **MR. GRIFFON:** Everyone on the line, we're ready
19 start here. I think we have just -- just a
20 second here to close out on the procedures
21 review section. Stu, you had a comment.

22 **MR. HINNEFELD:** I had -- I had one comment to
23 make. One of the -- one of the proposed
24 actions on the matrix from earlier was to --
25 for SC&A to sit in on closeout interview -- a

1 closeout -- or closeout interviews, and we're
2 proceeding to -- down that pathway. I just
3 wanted to make one comment about the proposed
4 course of action, which was they would listen
5 in, write the report and then share it with the
6 claimant. I want to make sure OGC weighs in on
7 that because having the claimant review -- this
8 is an active claim. Now this is not a claim
9 that's closed. And so presenting this product
10 to an active claimant departs pretty far from
11 what we've ever done. And so I -- I want to --
12 I just want to put in there, I'm not so sure
13 that we want -- that we'll be able to
14 accommodate providing the product to the
15 claimant to review.

16 **DR. MAKHIJANI:** Okay.

17 **MR. HINNEFELD:** Because the claimant's
18 participation -- I mean, this -- this audit
19 process is sup-- not supposed to perturb --

20 **MR. GRIFFON:** Yeah.

21 **MR. HINNEFELD:** -- the claimant's par--
22 participation at all, because this is still an
23 active claim.

24 **MR. GRIFFON:** That might be a problem. I mean
25 that's inconsistent with what we've done before

1 --

2 **MR. HINNEFELD:** Yeah.

3 **MR. GRIFFON:** -- with other case reviews, so I
4 don't --

5 **MR. HINNEFELD:** So we'll set up the process,
6 and in fact it may already be, as I told Kate
7 yesterday -- yes, for sure, you know, ORAU will
8 initiate the contact and we'll re-- and we'll
9 initiate the scheduling. We think we have a --
10 a method that will work. But I'm -- I'm
11 concerned about having -- you know, introducing
12 a perturbation in the claimant's process.

13 **DR. MAKHIJANI:** I have a question about that.
14 Our -- you know, I think Stu sent us a set of
15 terms where SC&A would essentially be strictly
16 an observer and say nothing. And I think --
17 and I think that's ent-- entirely right and we
18 should say nothing. We -- we will, for our own
19 review process, have to document our
20 observations because you can't rely on memory.
21 I mean --

22 **MR. HINNEFELD:** Sure.

23 **DR. MAKHIJANI:** And so we're going to be making
24 some notes during this process. And the idea
25 of sending the notes both to the interviewer

1 and the interviewee for a fact-- was for a
2 factual check. Now if that's going to perturb
3 the -- as to -- as to whether the notes were
4 accurate or not -- and now if that's going to
5 perturb the process, then I -- I just have a
6 question about how is the documentation of the
7 interview to -- observation process to be
8 presented to the Board?

9 **MR. GRIFFON:** Well, I think -- I think you
10 might consid-- I mean I think where you may end
11 up is having -- sharing that -- your notes with
12 the interviewer for the factual check and
13 coming to agreement between the interviewer and
14 -- and the observer --

15 **MR. HINNEFELD:** There's -- there's no
16 particular problem --

17 **MR. GRIFFON:** Yeah.

18 **MR. HINNEFELD:** -- with noting and making notes
19 and --

20 **MR. GRIFFON:** Right.

21 **MR. HINNEFELD:** -- preparing your product. But
22 what I think the concern -- the effect of the
23 concern is perturbing the process --

24 **MR. GRIFFON:** Right.

25 **MR. HINNEFELD:** -- for an active claimant.

1 **MR. GRIFFON:** I don't think we can go there.

2 **DR. MAKHIJANI:** Right. And we don't want to do
3 that, obviously. There's -- there's no point.

4 **MR. GRIFFON:** So -- but I think that the rest
5 of the process is fine. Right, Stu? The rest
6 --

7 **MR. HINNEFELD:** As far as I know the rest is
8 fine.

9 **MR. PRESLEY:** And -- and then it could be
10 redacted when it comes back to the Board.

11 **MR. GRIFFON:** Right. Present it to the Board -
12 -

13 **MR. PRESLEY:** There's no problem there.

14 **MR. HINNEFELD:** Well, yeah -- the Board is
15 entitled to see unredacted information.

16 **MR. GRIFFON:** We can see the Privacy Act --
17 yeah.

18 **MR. HINNEFELD:** If we're going to make it
19 public -- if we want to make it public we would
20 have to redact it.

21 **MR. PRESLEY:** Right.

22 **DR. MAKHIJANI:** Okay.

23 **MR. GRIFFON:** And it's not clear to me that the
24 -- I mean, a redacted version in this -- in
25 this instance is probably adequate.

1 **MS. MUNN:** Yeah. I think so.

2 **MR. GRIFFON:** We're not looking for who, we're
3 looking for -- you know --

4 **MS. MUNN:** No. We're not looking for who,
5 we're not looking for buildings --

6 **MR. GRIFFON:** Right, right.

7 **MS. MUNN:** -- we're not even looking for site.

8 **MR. GRIFFON:** But anyway -- yeah, yeah.

9 **DR. MAKHIJANI:** Yeah, no.

10 **MR. GRIFFON:** Yeah.

11 **DR. MAKHIJANI:** It was -- it was just so we're
12 not relying on our memory of a complex process
13 in order to doc-- you know, in order to arrive
14 at conclusions from --

15 **MR. HINNEFELD:** Yeah, there's no problem with
16 preparing a -- a report or a product --

17 **MR. GRIFFON:** Yeah.

18 **MR. HINNEFELD:** -- from listening in. I think
19 it's the perturbation --

20 **MR. GRIFFON:** So I think sharing it with the --
21 sharing with the claimant is not going to
22 happen then. Right?

23 **DR. MAKHIJANI:** Okay. I mean --

24 **MR. HINNEFELD:** I believe that's probably where
25 we would have to --

1 **MR. GRIFFON:** I'm asking SC&A if you're -- if
2 you're agreeing with it right now. You don't
3 have to get a read from your legal.

4 **DR. MAKHIJANI:** Well, if there's any -- if it's
5 questionable in any way from the point of view
6 of perturbing the process, I'd -- I'd
7 personally actually rather not--

8 **MR. GRIFFON:** Right.

9 **DR. MAKHIJANI:** -- go there.

10 **MR. GRIFFON:** Right.

11 **MR. HINNEFELD:** Yeah.

12 **MR. GRIFFON:** So it's -- strike that, we won't
13 ask for that.

14 **MR. HINNEFELD:** Yeah.

15 **MR. GRIFFON:** Okay. Anything else on
16 procedures review? I think we're ready to go
17 into the second set of cases, at least start it
18 before lunch, and maybe -- you know, I -- I
19 think we'll go through most of these fairly
20 quickly. We've been doing this for a while.
21 These cases date back a ways. So, okay --
22 everyone have that matrix in front of them?

23 **SUMMARY OF FINDINGS MATRIX CASES 21 THROUGH 38**

24 It's "Summary of Findings Matrix Cases 21
25 through 38, prepared by the work group July

1 23rd through 2006." Lew, I don't know if we
2 have -- can we make copies available?

3 **DR. WADE:** We can. I can have copies made, if
4 you would like.

5 **MR. GRIFFON:** I mean, I'm thinking for people
6 watching in here.

7 **DR. WADE:** Well, maybe I can give them my copy
8 and I can look over someone's shoulder.

9 **MR. GRIFFON:** So I'll go by the finding number.
10 Just for those on the phone, I'll read the --
11 go down the finding numbers. And I'm really
12 just going to go where -- where I have
13 something highlighted unless other people raise
14 other questions. So the first one -- sometimes
15 they're hard to read 'cause the finding and
16 response overlap into two pages but, you know,
17 we did the best we can to limit the pages on
18 this, but it's down to 60, I think -- 57.

19 **MS. MUNN:** Down to 60.

20 **MR. GRIFFON:** Yeah.

21 **MS. BEHLING:** Mark?

22 **MR. GRIFFON:** Yeah.

23 **MS. BEHLING:** I realize on the very first
24 finding, 21.1 --

25 **MR. GRIFFON:** Right.

1 **MS. BEHLING:** -- and we talked about this and I
2 gave you wrong information for the NIOSH action
3 under this first finding. This -- actually
4 this case is a Rocky Flats case and --

5 **MR. GRIFFON:** Oh, okay.

6 **MS. BEHLING:** -- it doesn't have to do with a
7 Hanford issue, although this Hanford issue
8 about the skin dose will come up later.

9 **MR. GRIFFON:** Okay.

10 **MS. BEHLING:** So I'm afraid we're going to have
11 to change --

12 **MR. GRIFFON:** So this wasn't a Rocky.

13 **MS. BEHLING:** -- this NIOSH action. This is a
14 Rocky issue. And --

15 **MR. GRIFFON:** What was the NIOSH action prior
16 to this? There was no action, was there? Or
17 was --

18 **MR. HINNEFELD:** Well, we were going to talk
19 about this --

20 **MR. GRIFFON:** Yeah.

21 **MR. HINNEFELD:** -- because there's a
22 discrepancy in the -- in the dose record I
23 think we can talk about today. It's really
24 minor.

25 **MS. BEHLING:** It -- it is minor.

1 **MR. HINNEFELD:** If we just talk about it a
2 little bit I think we can just say okay, good
3 enough. I have copies of some things if -- I
4 have -- I have made eight copies. I want to
5 make sure Hans and Kathy have one and I want to
6 make sure the Board members have one. I
7 suppose Ray should have one. Maybe everybody
8 else can share -- because it explains the
9 record and why this calculation error -- or
10 apparent calculation error appears in the dose
11 reconstruction.

12 **MR. GRIFFON:** Okay.

13 **MR. HINNEFELD:** Okay. Now what I just handed
14 out -- the packet I just handed out has
15 essentially a two-page excerpt from the dose
16 reconstruction review -- I'm sorry, a three-
17 page excerpt. The top three pages are from the
18 dose reconstruction review. And then I've
19 attached to that an additional -- oh, about
20 five or six pages which are additional
21 renditions of the occupational dose record for
22 this energy employee that line up with the --
23 the one sheet that's attached. You know, there
24 -- the -- Rocky Flats provides -- I'll call
25 them three different renditions of the

1 occupational exposure record with their -- with
2 the file. And so the -- the basis for the
3 arithmetic error is that shallow -- the -- the
4 shallow dose calculation is supposed to start
5 from the difference between shallow and deep
6 photon. Okay? And you take that difference
7 and that starts the calculation for -- for the
8 shallow dose. And in the page that's attached
9 to the finding -- in other words the third page
10 of the package I just handed out, and in the
11 rendition immediately behind that which is two
12 more pages, for the various years that are
13 highlighted -- well, it's exposure -- entry
14 lines 18, 19 -- or eight, nine, ten -- and they
15 are marked by little arrows on page two. For
16 those lines and those years there's a
17 discrepancy. If you use this exposure record
18 there really is no difference between shallow
19 and deep dose and so there shouldn't be a
20 shallow dose calculation, but on the dose
21 reconstruction report there is one.

22 Now, if you look at the final rendition of the
23 exposure history, this one -- this is the final
24 rendition of the exposure history for those
25 years -- and a good example is 19-- well, 1997

1 is a good example. It's on the first page of
2 the -- this record -- '77 -- 1977, I'm sorry,
3 1977. This -- this rendition provides what
4 appears to be components from various -- or,
5 yeah, doses from various dosimeter components
6 because you have a DDE or deep dose equivalent
7 -- which could be deep dose equivalent photon
8 dose -- you have SDE-SK, shallow dose
9 equivalent or skin dose photon, and then to the
10 right you have a column that says neutron.
11 And there's a number in that neutron for one of
12 the badges in 1977 and it's three, maybe we --
13 that just starts a whole 'nother debate and
14 subject to another finding. But on this sheet
15 there is a difference between the shallow and
16 the deep photon dose. So if you add up all the
17 nu-- all the 1977 -- there's more than one 1977
18 badge -- so if you add up all the 1977 badges
19 you have a difference between shallow and deep.
20 And so this -- this rendition of the dose
21 record which -- which appears to present the
22 photon shallow and the photon deep, and that
23 difference then is the starting point for the
24 dose calculations. That's why the dose
25 reconstruction was done. The numbers are so

1 small that it really doesn't matter. So we can
2 just, you know, go beyond that. But I did want
3 to explain that.

4 **MS. BEHLING:** Okay.

5 **MR. HINNEFELD:** Thank you.

6 **MR. GRIFFON:** Okay, so there's no action on
7 this then.

8 **MS. BEHLING:** No action.

9 **MR. GRIFFON:** We thought it was a Han-- I
10 thought it was Hanford, okay.

11 **MS. BEHLING:** Yeah, I misguided you there.

12 **MR. GRIFFON:** That's okay. It's those dogs
13 getting in our way.

14 All right, I'm on 21.2 -- 21.2. I didn't
15 highlight this and I'm wondering why. But in
16 -- in the NIOSH action column there's this
17 excerpt from a memo apparently, and I don't
18 know that we've seen the memo or anybody --

19 **MR. HINNEFELD:** It's an e-mail.

20 **MR. GRIFFON:** It's an e-mail?

21 **MR. HINNEFELD:** Yeah.

22 **MR. GRIFFON:** Oh, it's just e-mail. Okay.

23 **MR. HINNEFELD:** I can forward it.

24 **MR. GRIFFON:** Yeah, I think so. It --

25 (Pause)

1 Yeah, I guess we just wanted to see -- so it's
2 not a -- it's not a -- nothing more than a e-
3 mail. It's not a procedure or policy --

4 **MR. HINNEFELD:** I give -- I give ORAU tons of
5 instructions in e-mails.

6 **MR. GRIFFON:** Okay.

7 **MS. BEHLING:** Thi-- this has not been
8 incorporated, say, into the revision to Proc 6
9 or anything -- this change in -- I'm going to
10 call it a change in -- in the NIOSH philosophy.
11 This, you know --

12 **MR. HINNEFELD:** I don't know if you'll find it
13 in Proc 6 or not, but -- I mean Proc 6 talks
14 about ORAU's thinking, gets kind of a -- but --
15 and some of them are maybe unnecessarily
16 generous -- but at least there is -- you know,
17 there is a prescribed -- there is a scri--
18 prescribed pathway, you know, for these things.
19 This instruction was -- rather than see dose
20 reconstructions with, you know, unnecessarily
21 high estimates -- just, you know, throw in some
22 doses just because you can 'cause nothing's
23 going to change -- we said you shouldn't do
24 that.

25 **MR. GRIFFON:** Right.

1 **MS. BEHLING:** Okay.

2 **MR. GRIFFON:** Right.

3 **MR. HINNEFELD:** Now there may be things that
4 are efficient that, on the face of it if you
5 look at it, don't seem efficient but really
6 are, based on the dose reconstruction tools.

7 **MS. BEHLING:** Okay.

8 **MR. HINNEFELD:** And you're going to commit to
9 tools.

10 **MS. BEHLING:** Yes.

11 **MR. GRIFFON:** Right, right.

12 **MS. BEHLING:** And we -- we understand that.

13 **MR. HINNEFELD:** Okay.

14 **MS. BEHLING:** And -- we certainly agree with
15 any efficiency process, but when -- as we've
16 said before -- you can go to a table or you can
17 look at things very easily and calculate the
18 correct information or the correct -- pick the
19 correct organ of interest, then we should do
20 that, and I just didn't know if that was going
21 to be reflected in -- in changes to Proc 6 --

22 **MR. HINNEFELD:** We'll --

23 **MS. BEHLING:** -- which is where I think it
24 should be.

25 **MR. HINNEFELD:** Again, there are -- there's a

1 tool that provides -- you know, there may be a
2 table where you can look up the true value, and
3 the tool may not have that built in.

4 **MS. BEHLING:** Okay.

5 **MR. HINNEFELD:** And the -- and the tool allows
6 you to do the overestimating technique that --
7 like I said, it doesn't necessarily look like
8 an efficiency, but it is --

9 **MS. BEHLING:** It is.

10 **MR. HINNEFELD:** -- as the dose reconstructor
11 and (unintelligible).

12 **DR. BEHLING:** I think what sometimes is
13 confusing is when you don't identify the
14 reference. Obviously, if you use the TBD which
15 is site-specific -- and they give you LOD
16 values and they differ from the generic TIB-8
17 or 10 --

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

19 **DR. BEHLING:** -- I would say either one is
20 fine. If you're going to overestimate, use the
21 complex-wide generic procedure such as 8 or 10,
22 realizing that those numbers may not
23 necessarily agree with the TBD for a specific
24 time frame.

25 **MR. HINNEFELD:** Right.

1 **DR. BEHLING:** But if someone says a reference
2 then we sort of say, okay, that's what they
3 used and this is how they document the ultimate
4 value that's entered into the IREP input. And
5 -- and sometimes that's not necessarily clear,
6 so you don't know which document they use,
7 realizing that there's some disagreement when
8 you deal with the complex-wide versus site-
9 specific documents.

10 **MS. BEHLING:** And I think we're -- we're
11 jumping ahead here a little bit with this
12 issue.

13 **MR. GRIFFON:** I was just -- I'm thinking the
14 same thing. Go ahead, yeah.

15 **MS. BEHLING:** Since -- since Hans mentioned it,
16 though --

17 **MR. GRIFFON:** The workbook.

18 **MS. BEHLING:** -- the workbook issue is in
19 referencing the workbooks, that's typically not
20 done in dose reconstruction reports. So if it
21 was referenced there, then I think that would
22 also help us to not identify something like
23 this as a finding. But that's going to come up
24 again --

25 **MR. GRIFFON:** Right.

1 **MS. BEHLING:** -- later.

2 **MR. GRIFFON:** That'll come up later, but we've
3 got it now. Okay, I -- so I -- the same thing
4 is on 21.3. I'm not going to go through that.
5 I -- Stu, just if you can provide that e-mail
6 to us --

7 **MR. HINNEFELD:** Yeah. I -- I'm confident I can
8 find it --

9 **MR. GRIFFON:** -- I don't think there's any
10 question -- I think we all are in agreement
11 that that's the appropriate policy.

12 **MR. HINNEFELD:** Right.

13 **MR. GRIFFON:** I'm going to scan down. I'm
14 looking through case 21. And if anybody has
15 anything, certainly step in, but I'm down to
16 case 22 now. Case 22 finding 22.7-B.3, to be
17 specific. Well, this sort of -- we discussed
18 in the --

19 **MS. BEHLING:** In the procedures.

20 **MR. GRIFFON:** -- in our procedures review,
21 yeah. So I think the CATI question is -- is
22 going to be covered in there so I'm willing to
23 sort of defer that to that section, if you guys
24 are okay with that.

25 **MS. BEHLING:** Yes.

1 **MR. GRIFFON:** From IG-1.

2 **MR. HINNEFELD:** There's a kind of recurring
3 theme that measured dose isn't always captured
4 in the normal distribution and in ca-- in this
5 particular case, probably should have been a
6 normal distribution. So we're thinking about
7 how we get that instruction out there.

8 Procedure 6 seems to be the li-- logical place
9 for it to be. If we deviate from that and
10 decide it should be somewhere else, we'll let
11 you know -- but I think Procedure 6 is the
12 place for that guidance to be.

13 **MR. GRIFFON:** So is that -- I'll keep that in
14 the action now and if you deviate from that
15 you'll --

16 **MR. HINNEFELD:** Yeah.

17 **MR. GRIFFON:** -- you'll explain why.

18 **MR. HINNEFELD:** Yeah.

19 **MR. GRIFFON:** Yeah. All right.

20 **MS. BEHLING:** What's the comment -- excuse me,
21 but -- "re-evaluate case 23 in light of
22 comments provided" -- what --

23 **MR. GRIFFON:** Oh. Yeah.

24 **MR. HINNEFELD:** Well, there -- there were
25 enough -- there were enough items on here that

1 I thought should be reworked that we just
2 wanted to rework those, you know -- the case.
3 You know, take into account all of the findings
4 here, rework the case with these findings.

5 **MS. BEHLING:** And -- and that's being done?

6 **MR. HINNEFELD:** Yeah.

7 **MR. GRIFFON:** Okay.

8 **DR. BEHLING:** Let me ask a couple of things,
9 because it's been brought up on previous
10 dialogue that we've had with you and Jim Neton
11 on the issue of uncertainty which frequently
12 was not used, but I think in this -- with the
13 addition of workbooks which do the calculations
14 for you, I think that problem is by and large
15 resolved. But early on, it was discussed that
16 the issue of -- of uncertainty, when it's not
17 necessarily identified, is compensated by
18 claimant-favorable selection of DCFs that would
19 potentially compensate for the absence of an
20 uncertainty. Is that still a policy to --

21 **MR. HINNEFELD:** They're -- we're eval-- there's
22 -- one of our actions on here is to evaluate --
23 to show whether that's an -- under what
24 conditions is that --

25 **DR. BEHLING:** Okay.

1 **MR. HINNEFELD:** -- use of a DCF of one --

2 **DR. BEHLING:** Yes, a DCF of one --

3 **MR. HINNEFELD:** -- in place of a triangular DCF
4 that's below one, times the normal distribution
5 and is that sufficiently favorable -- that
6 evaluation's pretty far along.

7 **MR. GRIFFON:** That is action. That is an
8 action on here.

9 **MR. HINNEFELD:** We've got to run it model by
10 model so it's a lot of calculation to do, but
11 it's -- or organ by organ, because of
12 combinations and (unintelligible) and risk
13 code, so -- IREP models, so -- but yeah, we're
14 pretty far along in that effort to illustrate -
15 - so I have calculations to illustrate that
16 that decision goes down the normal distribution
17 times the triangular DCF.

18 **MR. GRIFFON:** Okay. Hans? You okay?

19 **DR. BEHLING:** Yeah. Yeah. Yeah -- it would be
20 helpful, however, in doing the audit, in -- in
21 perhaps making a note of that so that we don't
22 end up citing it as an issue --

23 **MR. HINNEFELD:** Right.

24 **DR. BEHLING:** -- when in fact that becomes a
25 no-issue.

1 **MR. GRIFFON:** Well if -- if workbooks are
2 referenced, that's the other action --

3 **DR. BEHLING:** Yes.

4 **MR. GRIFFON:** -- then you would know. Right?

5 **DR. BEHLING:** Yes.

6 **MR. GRIFFON:** That --

7 **DR. BEHLING:** Well, when a claimant-favorable
8 DCF is used, then perhaps the tedious task of
9 doing an uncertainty analysis is not necessary.

10 **MR. GRIFFON:** Right.

11 **MR. HINNEFELD:** Right.

12 **MR. GRIFFON:** All right. We're -- you okay
13 over there, Ray?

14 **THE COURT REPORTER:** Yeah. I just realized he
15 moved again.

16 **MR. GRIFFON:** Yeah.

17 **MR. HINNEFELD:** They don't want to make it easy
18 for you, Ray. You're the world champ, come on.

19 **MR. GRIFFON:** Down to case 24. We should
20 clarify the record, I don't think he is world
21 champ.

22 **MS. MUNN:** Yeah, he is.

23 **MR. PRESLEY:** In our book he is.

24 **MR. GRIFFON:** Silver medalist, but he's our
25 world champion.

1 **MR. PRESLEY:** He's the world champ.

2 **MS. MUNN:** Nobody does it better.

3 **MR. GRIFFON:** Oh, no, Wanda's breaking into
4 song. I knew it would come to this.

5 **MS. MUNN:** We've gone too long.

6 **MR. GRIFFON:** Case 24 we're on, and I think I
7 -- I didn't change anything in the action
8 column. I believe I tried to highlight --

9 **MS. BEHLING:** And we talked about this earlier
10 and TIB-8 and 10 have been revised. And we did
11 look -- and I'll correct the record -- we did
12 look out on the O drive and both of those
13 procedures are there now.

14 **MR. GRIFFON:** Are there, yeah, so we're -- and
15 -- and as John said, as a course of action to
16 carry through these, I -- I think we -- we have
17 SC&A -- it's "SC&A will review these," at least
18 with respect to the findings here.

19 **DR. MAURO:** I guess -- does (unintelligible)
20 need another column on this thing eventually
21 saying, you know --

22 **MR. GRIFFON:** Well, we're going to have a list
23 of actions out of this -- from this --

24 **MR. HINNEFELD:** Maybe we could track that on
25 the action item list --

1 **MR. GRIFFON:** Yeah.

2 **MR. HINNEFELD:** -- as opposed to this matrix?

3 **MR. GRIFFON:** Yes. Yeah, I think we -- we'll
4 try to close this matrix --

5 **DR. MAURO:** Okay, move the ma-- yeah, we talked
6 --

7 **MS. MUNN:** Yeah.

8 **MR. GRIFFON:** Close the matrix and have a
9 listing of ac-- ongoing actions.

10 **MR. BUCHANAN:** You say that the new version of
11 8 and 10 are on the O drive now?

12 **MS. BEHLING:** Yes. Yes.

13 **MR. GRIFFON:** Yes, they are, yeah. We'll find
14 --

15 **MS. BEHLING:** Let me just ask a question.
16 John, are we going to review the entire 8 -- on
17 8 and 10, or are we only looking specifically
18 at these issues? Because 8 and 10 has not been
19 -- is not part of our supplemental procedures.

20 **DR. MAURO:** Yeah, I -- I guess my reaction is
21 we're only going to review it with respect to
22 this issue.

23 **MR. GRIFFON:** But -- but the issue was that
24 they were ambiguous, so I think you're going to
25 end up --

1 **DR. MAURO:** Well, then we're forced to. You
2 know what I'm saying -- I'd like, as a matter
3 of policy, keep it cl-- you know, to be
4 responsive to this particular issue.

5 **MR. GRIFFON:** To the finding, right.

6 **DR. MAURO:** Now if the issue is -- is of a
7 general nature where we have to review the
8 whole thing, that's what we'll do.

9 **MS. BEHLING:** Okay. Because that's what -- we
10 will have to do it on this case.

11 **DR. BEHLING:** And it -- and it may come up in
12 the -- the litmus test of having resolved the
13 ambiguity of the procedure will be tested when
14 we look at future audits where that particular
15 TIB will be used. And -- and at this point, we
16 can only make a very subjective evaluation
17 regarding the clarity of the procedure.

18 **MS. BEHLING:** However those TIBs were just
19 issued, and it's not likely we're going to see
20 those cases for quite some time.

21 **MR. HINNEFELD:** Not for a while.

22 **MR. GRIFFON:** Yeah.

23 **MS. BEHLING:** Any cases that would use tho--
24 the revised TIB, we just -- you just don't get
25 -- it doesn't get through the process quick

1 enough for us to see them. It will probably be
2 a year --

3 **MR. HINNEFELD:** We're at least months away-- at
4 le-- way-- at least months -- could be a year.

5 **MS. BEHLING:** Yes.

6 **MR. GRIFFON:** And -- and I'll let -- I mean I
7 think John may want to discuss with Lew, you
8 know, any kind of -- as we -- as you look at
9 the scope of what's generated out of this, the
10 -- any contracting concerns. Because it -- it
11 -- I mean, I'm thinking if -- if an action is
12 always -- I mean we have several actions that
13 were to, you know, defer to a new procedure or
14 defer to this or -- or clarify it in this, and
15 it seems like that may be sort of a change
16 order -- but, you know --

17 **MR. HINNEFELD:** Right.

18 **DR. WADE:** We have a lot of flexibility under
19 Task III so I think we can accommodate it.

20 **MR. GRIFFON:** Yeah. Okay. It's beyond my
21 scope.

22 **DR. MAURO:** (Unintelligible) Task III because
23 it -- they're smaller chunks.

24 **MR. GRIFFON:** Okay.

25 **DR. WADE:** And there's a lot of them that are

1 scheduled new for a year, so we should be able
2 to accommodate them.

3 **MR. GRIFFON:** Okay. I just didn't to put you
4 in a bind that way.

5 Okay. Down to case 25, I think. No?

6 **DR. BEHLING:** No, can I just make a comment,
7 because it's appropriate at this point to
8 perhaps state something. TIB-8 and 10 have
9 been notorious sources of findings in the past,
10 including through the fourth set.

11 **MR. GRIFFON:** Yeah.

12 **DR. BEHLING:** I think starting in the future --
13 and we will, probably for the next conceivable
14 time frame, look at similar problems that
15 involve TIB-8 and 10, because as -- as we just
16 finished mentioning, chances are we won't see
17 the benefit of the revisions to those TIBs for
18 a long time. We're not going to cite them
19 again as a finding. We will possibly make an
20 observation without having to go through the
21 matrix, because at this point we have resolved
22 the issue. And so hopefully --

23 **DR. MAURO:** No. I -- I'm sorry. This goes
24 toward -- and a funny -- in a way the Task IV
25 proposal -- that is, what we're getting at here

1 is that right now, to -- to repeat a finding
2 again and again and again in each one of our
3 audit reports line item and an IREP--

4 **MR. MAHER:** The -- the speaker needs to get
5 closer to the mike.

6 **DR. MAURO:** I guess this -- this might be a
7 good example of something that we're going to
8 be discussing either at the next full Board
9 meeting on the conference call or in September,
10 and this is a good preview for it. There are
11 certain efficiencies SC&A could incorporate
12 into our audits of cases which would allow us
13 to -- to more quickly process the audit, and
14 this would be an example. That is, if there --
15 if as you're going through it, if there's a
16 TIB-8, 10 issue that is self-evident, rather
17 than spending time working it up, working it
18 into the report, we can just move on to -- to
19 new issues and not just rehash old issues. And
20 this is a judgment call that right now in our
21 proposal that all of the Board members has
22 before them now, we actually pr-- provide an
23 option. One of the options is -- we probably
24 can -- for the same price, we can probably do a
25 lot more cases if we are given a certain amount

1 of leeway of not having to, you know, delve
2 into some of the issues. And this is a tough
3 call, whether -- you know, it means that we
4 would have -- rather than being as strict in
5 terms of our audits as we were in the past
6 where we went over every line and checked every
7 number, now there would be a certain degree of
8 discretion. I think that's the word we
9 actually used in our proposal, leaving Hans and
10 Kathy and the rest of the team with a certain
11 amount of discretion on which particular issues
12 we will pursue and which ones really represent
13 things that we've already talked about and
14 really don't require us to spend very much time
15 on. So this is -- I -- all I'm saying is, this
16 is a topic we will probably just have to
17 discuss before the full Board, but it's a good
18 opportunity now at least to introduce it to the
19 working group and the Board members here, that
20 we will be engaging this. I see an efficiency
21 on our end now, coming in, if we can do this.

22 **MR. GRIFFON:** I think we have to carefully
23 consider it. I mean I'll --

24 **DR. MAURO:** Yes.

25 **MR. GRIFFON:** -- wait for your proposal, but I

1 --

2 **MS. BEHLING:** Right.

3 **MR. GRIFFON:** -- you know, the downside of it
4 is, you have to remember that we're doing a
5 percentage of cases -- I mean that the goal of
6 the overall audit -- and if you start to not
7 look at some of these -- you know, it may be
8 old news, but we're only doing -- you know, in
9 the overall picture it should still be listed
10 as a finding and just -- we would just
11 streamline the resolution process. In other
12 words, we know what you -- what you've done, so
13 we don't need to, you know --

14 **MS. BEHLING:** Mark, excuse me just one second,
15 because I've given that some thought also and I
16 -- what I was going to consi-- going to
17 recommend doing for the fifth and sixth sets is
18 a situation like this where we know a revision
19 has ma-- been made to 8 and 10 but we're still
20 looking at older dose reconstructions --

21 **MR. HINNEFELD:** Right.

22 **MS. BEHLING:** -- rather than making it a
23 finding in the write-up, we make it an
24 observation, and possibly even capture it by
25 making a change to our checklist, where we

1 still state no. But rather than high, medium,
2 and low under the significance, we could make
3 it an observation indicating -- or some
4 indication that this is an issue that's already
5 been resolved.

6 **MR. GRIFFON:** But what's the benefit of
7 downgrading it to an observation?

8 **DR. BEHLING:** The fact that it doesn't end up
9 in a matrix and go through --

10 **MS. BEHLING:** So it doesn't get -- get into a
11 matrix process.

12 **DR. BEHLING:** -- this whole issue of
13 resolution. I mean, the purpose of a matrix is
14 to find resolution to existing problem. We
15 have solved the problem with the revision of
16 TIB-8 and 10.

17 **MR. GRIFFON:** But -- but you've solved the --
18 but you're not getting my point. My point is
19 that you -- if you're looking at an overall
20 program review, you -- you solved the problem,
21 but it still existed in these other cases --

22 **DR. BEHLING:** Yes.

23 **MR. GRIFFON:** -- that you've come across. So
24 now you're saying, well, it's old news so we're
25 -- sort of downgrading it to an observation.

1 You know, I know there's no more resolution to
2 be done, but I hate to --

3 **DR. BEHLING:** How about a finding with an
4 asterisk, that says --

5 **MR. GRIFFON:** Well, yeah. Something like that.
6 I think we can get there.

7 **DR. BEHLING:** -- it's been resolved. It
8 doesn't have to be entered into a matrix.

9 **MR. GRIFFON:** I'm saying streamline the work
10 but maybe don't -- don't disregard it as a
11 finding, 'cause --

12 **MS. BEHLING:** It would certainly become a
13 finding if it --

14 **MR. GRIFFON:** Yeah.

15 **MS. BEHLING:** -- you know, significantly
16 impacted the case in any way on that individual
17 case.

18 **DR. BEHLING:** Well, those are -- it wouldn't.
19 They're -- and they're --

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

21 **DR. BEHLING:** -- basically, these two TIBs used
22 to estimate maximized doses and the likelihood
23 that it would ever impact a claim that goes
24 from non-compensable to compensable is
25 virtually nil. And so it's -- it has limited

1 value --

2 **MR. GRIFFON:** Yeah.

3 **DR. BEHLING:** -- in that regard.

4 **MS. BEHLING:** Yeah.

5 **MR. GRIFFON:** It may be that they were sort --
6 yeah -- probably in the observation category
7 all along, you know.

8 **DR. BEHLING:** Yeah.

9 **MR. GRIFFON:** Yeah.

10 **DR. BEHLING:** Well, it's -- it's a finding that
11 has a low impact --

12 **MR. GRIFFON:** Right.

13 **DR. BEHLING:** -- as we always acknowledge.

14 **MR. GRIFFON:** As we -- as we acknowledge, yeah.

15 **MS. BEHLING:** Maybe we can keep it a finding
16 with an asterisk just to alert everyone that
17 this is something that's already been resolved.

18 **DR. BEHLING:** And really should not be --

19 **MR. GRIFFON:** Or we'll de-- we just know in the
20 path forward there's no resolution process,
21 yeah, we don't fret.

22 **DR. BEHLING:** Yeah, it should not be part of
23 the next matrix.

24 **MR. PRESLEY:** Yeah, and it stops right there.

25 **MR. GRIFFON:** We don't -- we don't bog it down

1 in the matrix process.

2 **MS. BEHLING:** Right.

3 **DR. BEHLING:** Yes. That's what I want to
4 avoid, the issue of having a 30, 40-page matrix
5 where you said -- when in fact the issue has
6 been resolved.

7 **MR. GRIFFON:** Right, right. I get -- I -- okay.
8 All right.

9 So back to -- I'm up to case 25. Only stopping
10 if I hear something. Case 26 -- 26.1 I have
11 something. Always-- and I think this is okay,
12 I just added this but -- Stu, this was not from
13 you. I added it as a NIOSH response. Don't
14 want to put words in your mouth, but I think
15 it's -- it was at the bottom of -- of the
16 finding, really, or the -- it was at the bottom
17 of the third column in the matrix there.

18 **MR. HINNEFELD:** That's fine.

19 **MR. GRIFFON:** That a class has been added for
20 Iowa, so --

21 **MR. HINNEFELD:** Okay.

22 **MR. GRIFFON:** -- okay. And there's no action
23 on these.

24 **MS. MUNN:** That's 26. Right?

25 **MR. GRIFFON:** Yes, 26. And it goes on for the

1 next couple --

2 **MS. MUNN:** Yeah.

3 **MR. GRIFFON:** -- same thing. Okay --

4 **MS. MUNN:** Number 27?

5 **MR. GRIFFON:** -- 27.1 --

6 **MS. BEHLING:** This is what we talked about
7 earlier.

8 **MR. GRIFFON:** Yes, yes.

9 **MS. BEHLING:** And this is -- that it would be
10 helpful for us when a workbook is used, that it
11 actually be referenced -- and possibly even the
12 version of that workbook be referenced -- in
13 the dose reconstruction report. That would
14 certainly be helpful me.

15 **MR. HINNEFELD:** That would be easy to do in the
16 revised DR format that we're looking at --

17 **MS. BEHLING:** Okay.

18 **MR. HINNEFELD:** -- in the health physicist
19 portion of that DR. That would be easy to put
20 in there.

21 **MS. BEHLING:** Okay.

22 **MS. MUNN:** Good. That would be nice.

23 **MR. GRIFFON:** So it -- the reference would be
24 in the DR. Right?

25 **MR. HINNEFELD:** Yeah.

1 **MR. GRIFFON:** Not in the procedures. I think I
2 misstated that.

3 **MS. BEHLING:** In the DR.

4 **MR. HINNEFELD:** DR.

5 **MR. GRIFFON:** Because a lot of the proce-- a
6 lot of the tools are related -- not all the
7 tools are related to procedures.

8 **MS. BEHLING:** No.

9 **MR. HINNEFELD:** Ah, procedures, TIBs, you know
10 -- other -- they -- they should all draw their
11 information from a published technical
12 document.

13 **MR. GRIFFON:** Right.

14 **MR. HINNEFELD:** But now which one you're -- I -
15 - I see your point -- where you draw from,
16 where's it drawn from.

17 **MS. BEHLING:** Yeah.

18 **MR. HINNEFELD:** I think that -- our -- our
19 envisioned rewrite of the dose reconstruction
20 format where we're going to have a section for
21 the health physicist would allow us to -- I
22 think -- list pretty clearly what tool is used.

23 **MS. BEHLING:** Okay. That'd be con-- very
24 helpful.

25 **MR. GRIFFON:** Now I didn't number this, but it

1 -- would this be a NIOSH action?

2 **MR. HINNEFELD:** Yeah.

3 **MR. GRIFFON:** I don't have your numbering
4 system -- we can -- we can get that later. I
5 can.

6 **MR. HINNEFELD:** I can -- I can in-- I can tell
7 you if I can just -- if I can remember it real
8 quick. DR -- this would be DR 27.1.

9 **MR. GRIFFON:** DR 27.1. And it -- it should
10 read --

11 **MR. HINNEFELD:** And this is the only place it
12 appears.

13 **MR. GRIFFON:** It should read --

14 **MR. HINNEFELD:** Yeah.

15 **MR. GRIFFON:** -- "NIOSH will reformat DR report
16 language to --"

17 **MR. HINNEFELD:** Yeah.

18 **MR. GRIFFON:** " -- include..."

19 **MS. MUNN:** Reference workbooks, uh-huh.

20 **MR. HINNEFELD:** Let's just say -- yeah -- yeah.

21 **MS. MUNN:** Uh-huh, "Procedures will be revised
22 to reference workbooks in the DRs".

23 **MS. BEHLING:** DRs.

24 **MR. HINNEFELD:** No, it's the DR. Refor-- the
25 reformatted DR will reference the workbook.

1 said that NIOSH is looking into this issue.
2 When workbooks are used, yes, SC&A is reviewing
3 that issue among -- within Task III and the
4 workbook evaluations.

5 **MR. GRIFFON:** But is there a NIOSH action on
6 this you're saying, too?

7 **DR. MAURO:** There -- there's this last sentence
8 here about -- however, I -- we're looking at
9 27.5 right now.

10 **MR. GRIFFON:** Uncer-- uncertainty, yeah.

11 **DR. MAURO:** Yeah, there's just something here
12 about uncertainty -- additional uncertainty,
13 which goes over and above, I guess, just making
14 reference to the workbook and whether or not
15 there's an action here dealing with additional
16 uncertainty that might be -- need to be
17 incorporated.

18 **DR. BEHLING:** That was basically part of the
19 implementation guide because it's really the
20 implementation guide that identifies the three
21 --

22 **DR. MAURO:** Yes.

23 **DR. BEHLING:** -- components of uncertainty.

24 **DR. MAURO:** Okay.

25 **DR. BEHLING:** -- and -- and so if -- if the

1 revised implementation guide 01 addresses that,
2 then it satisfies this as an issue.

3 **MR. HINNEFELD:** Yeah, that's where we describe
4 uncertainty approaches. And the id-- and so
5 while these -- what they describe there are
6 laboratory uncertainties on individual badge
7 reading, you know, in application the
8 uncertainty's applied to an annual total which
9 may be 12 badge readings. And so the
10 uncertainty sort of converges as you combine
11 multiple badge totals. So I think we have in
12 our revision IG-1 -- I think we have a
13 description of the basis for uncertainty.
14 That's what we're supposed to have, the basis
15 for the uncertainty we're using.

16 **DR. BEHLING:** And -- and the workbooks usually
17 reflected that methodology.

18 **MR. HINNEFELD:** Yes. Yes.

19 **MR. GRIFFON:** So that -- that action stands as
20 an SC&A action?

21 **MS. BEHLING:** Yes.

22 **MR. GRIFFON:** Is that okay, Stu, that --

23 **MR. HINNEFELD:** Yeah.

24 **MS. MUNN:** That's been captured in "Revise IG-
25 1". Right?

1 **MR. GRIFFON:** What's that, Wanda? Should I add
2 some --

3 **MR. HINNEFELD:** That -- that -- she was making
4 a --

5 **MS. MUNN:** That I was say-- I was just saying
6 -- which has been captured in the revised IG-
7 001.

8 **MR. GRIFFON:** Yeah. Right -- I'm down to 28.1,
9 finding 28.1-C.1-1. Oh, this is the same
10 thing. Right?

11 **MS. BEHLING:** Can we go back --

12 **MR. GRIFFON:** Yeah.

13 **MS. BEHLING:** I'm sorry, Mark. Can we go back
14 to 27.9?

15 **MR. GRIFFON:** Twenty-seven point nine. Okay.
16 Oh, yeah.

17 **MS. BEHLING:** This is an action regarding the
18 -- (unintelligible). Okay, maybe this is -- is
19 this covered by the new Proc 60? Am I in the
20 wrong --

21 **MR. HINNEFELD:** Okay, this has -- this has to
22 do with that there were several -- the SRS site
23 profile gives all these -- a variety of options
24 for doing ambient depths. That's the nut of
25 this one. Right?

1 **MS. BEHLING:** Oh, yes.

2 **MR. GRIFFON:** Yeah.

3 **MR. HINNEFELD:** I guess my preference would be
4 we move that into Savannah River site profile
5 since it's the site profile where the stuff's
6 written. And Proc 60 is the new -- either 60
7 or 61, I can't keep them straight --

8 **MR. GRIFFON:** Sixty.

9 **MS. BEHLING:** Sixty.

10 **MR. HINNEFELD:** Sixty. Proc 60's a new ambient
11 dose one, so I don't -- I don't really know if
12 it specifically says about, you know --

13 **MS. BEHLING:** Yeah.

14 **MR. HINNEFELD:** -- what to do about Savannah
15 River or not.

16 **MS. BEHLING:** Is Savannah River's specific data
17 incorporated into 60? I know there's a few --

18 **DR. MAURO:** The table there (unintelligible) --

19 **MR. GIBSON:** Mark?

20 **MR. GRIFFON:** Yes.

21 **MR. GIBSON:** I'm having a hard time hearing the
22 lady that's speaking.

23 **MS. BEHLING:** Kathy, I'm sorry.

24 **MR. GRIFFON:** Okay, Kathy, yeah -- we'll --
25 we'll get her to speak up. Sorry, Mike.

1 **MS. BEHLING:** I'm sorry, Mike. It's Kathy
2 Behling.

3 **MR. GIBSON:** Okay. Thanks, Kathy.

4 **MS. BEHLING:** Okay. I was just questioning
5 from back on 27.9 -- finding 27.9. We
6 indicated that they were going to reconsider
7 two KBS 00 -- yeah 003, which is the Savannah
8 River site technical basis document -- and I
9 wasn't sure if the new procedure, Proc 60, may
10 already incorporate Savannah River Site's
11 specific data.

12 **MR. HINNEFELD:** It's not in the data table.

13 **MS. BEHLING:** Okay.

14 **MR. HINNEFELD:** There is a -- there's a note to
15 the data table that refers to a specific table
16 in the site profile -- in the Savannah River
17 site profile.

18 **MS. BEHLING:** Okay, because I thought -- I
19 thought possibly this would be resolved through
20 60, but --

21 **MR. HINNEFELD:** It's not resolved through 60.

22 **MS. BEHLING:** It's -- no, it's not.

23 **MR. HINNEFELD:** I think it should be moved to -
24 - it's a site profile issue, though, and should
25 be taken care of there, which is under -- that

1 -- that discussion's ongoing, too.

2 **MR. GRIFFON:** Yeah. So this -- this item being
3 tracked is where we'll get there. Right?

4 **MR. HINNEFELD:** Yes.

5 **MR. GRIFFON:** Yeah.

6 **MR. HINNEFELD:** Yes. I'm trying -- making a
7 mental note to myself how I'm going to do that,
8 but yes.

9 **MR. GRIFFON:** Okay. All right, 28.1? This is
10 the same tool question being referenced, I
11 think.

12 **MS. BEHLING:** Yes.

13 **MR. GRIFFON:** That's all we need in there.

14 **MR. GRIFFON:** And if I have the same thing --
15 and that's still going to be -- Stu, to stay
16 with your numbering system, that'll still be
17 27.1. Right? DR (unintelligible) --

18 **MR. HINNEFELD:** Yes. Yeah. Once it's -- the
19 first time it appears.

20 **MR. GRIFFON:** Once it's the -- right. That's
21 what I thought. So I'll carry that through for
22 the next several here. The next four have
23 that. If you feel it's inappropriate, let me
24 know. Then I'm down to case 28.13 actually,
25 "SC&A will review under Task III work." Is

1 **MR. GRIFFON:** Okay.

2 **MR. HINNEFELD:** The issue is this, that the
3 comment was made. There's no need to -- if
4 you've got a shallow dose there's no need to
5 apportion it among, you know, what's photon,
6 what's do-- what's beta, because it -- it's the
7 shallow dose.

8 **MR. GRIFFON:** Right.

9 **MR. HINNEFELD:** When in fact the range
10 effectiveness factor for beta particle's
11 different from a 30 to 250 KB photon. So if
12 you -- you know, in this case it's an
13 overestimate; it's just a bigger overestimate.
14 It doesn't matter. I mean they essentially
15 double-added it here. I mean so it was an
16 overestimate, but --

17 **MR. GRIFFON:** Yeah.

18 **MS. BEHLING:** It is --

19 **DR. BEHLING:** But -- but let me -- let me just
20 interject something. If you look at Appendix B
21 of Implementation Guide 1, and you look under
22 skin dose, there's a footnote up in the header
23 that says disregard all these things if you
24 have a seven milligram skin dose, which serves
25 as the way of assessing --

1 **MR. HINNEFELD:** Organ -- organ dose correction
2 factors.

3 **DR. BEHLING:** Yes.

4 **MR. HINNEFELD:** Okay.

5 **DR. BEHLING:** DCF.

6 **MR. HINNEFELD:** Right, for organ dose
7 correction factors.

8 **MS. BEHLING:** Two different issues.

9 **MR. HINNEFELD:** The difference is, in IREP a
10 thirt-- a two hun -- a 30 to 250 keV photon has
11 a higher radiological effectiveness factor than
12 the -- than a beta particle, which -- the beta
13 particle is the same as a high-energy photon.
14 So if you -- you can apportion out the skin
15 dose that comes from those photons, you know,
16 you actually have a higher risk. And so that's
17 why we apportioned it. Now in this case it was
18 done doubly. I think it was kind of thrown
19 into both beta and photon.

20 **MS. BEHLING:** It was. It was. And this has
21 been an oversight. And I did go back to the
22 TBD and the TBD does specify to do it this way.
23 It just seemed strange. And the -- these are
24 really two different issues --

25 **MR. HINNEFELD:** Okay.

1 **MS. BEHLING:** -- the photon component and then
2 the issue of the skin. And once you have the
3 seven -- seven milligram dose you don't have to
4 apply a DCF.

5 **MR. HINNEFELD:** Right. Gotcha. Gotcha.

6 **MS. BEHLING:** I think they're okay here.

7 **MR. GRIFFON:** Yeah, I think they're okay.

8 **MS. BEHLING:** Yeah.

9 **DR. BEHLING:** Was this a best estimate?

10 **MS. BEHLING:** No.

11 **MR. HINNEFELD:** No.

12 **MS. BEHLING:** Yes.

13 **MR. HINNEFELD:** No -- what -- was it?

14 **MS. BEHLING:** Or was this --

15 **DR. BEHLING:** I mean it seems like an awful lot
16 of investment in time to --

17 **MR. HINNEFELD:** Oh, it was a workbook. It was
18 a workbook.

19 **MS. BEHLING:** Yeah, this is a best estimate.

20 **MR. HINNEFELD:** This was workbook case. Right?
21 Wasn't 28 a workbook case?

22 **MS. BEHLING:** Yes.

23 **MR. HINNEFELD:** Okay.

24 **MS. BEHLING:** It was a best estimate.

25 **MR. GRIFFON:** Okay. All right.

1 **MS. BEHLING:** But that was a conservative
2 assumption. Okay.

3 **MR. GRIFFON:** Twenty-eight point thirteen. Is
4 that okay, that action, SC&A will rev--

5 **MS. MUNN:** Missed photon dose.

6 **MS. BEHLING:** Okay, one second.

7 **MS. MUNN:** And organ dose.

8 **MS. BEHLING:** This is Savannah River.

9 (Pause)

10 **MR. HINNEFELD:** So the -- is this the total
11 range? DCF -- the total range of the DCF using
12 -- being used in the workbook rather than the
13 AP range? Is that what this one is?

14 **MS. BEHLING:** I'm trying to get re-oriented. I
15 don't know, just a minute.

16 **MR. GRIFFON:** Okay.

17 **MS. BEHLING:** Yes, this will be covered under
18 the workbooks under Task III and it does have
19 to do with the range --

20 **MR. HINNEFELD:** Yep.

21 **MS. BEHLING:** -- and DCFs --

22 **MR. HINNEFELD:** Yep.

23 **MS. BEHLING:** -- and using -- they use the
24 min/max as opposed to --

25 **MR. GRIFFON:** The total min/max as opposed to

1 the AP min/max.

2 **MS. BEHLING:** Exactly.

3 **MR. GRIFFON:** Gotcha.

4 **DR. BEHLING:** Yeah. In fact, you'll see that
5 in the fourth set, too.

6 **MR. HINNEFELD:** Yep.

7 **MR. GRIFFON:** Okay.

8 **DR. BEHLING:** The workbook just defaults to the
9 lowest among the -- all four geometries.

10 **MR. HINNEFELD:** Yeah.

11 **DR. BEHLING:** And we've kind of agreed that --

12 **MR. HINNEFELD:** AP should be used.

13 **DR. BEHLING:** -- the AP geometry is the driver
14 at the moment.

15 **MR. HINNEFELD:** Yeah.

16 **MR. GRIFFON:** Okay. Looking ahead, we're
17 almost at lunchtime and I'm looking at the
18 clock. But I'm on to case 30, 30.1.

19 **MS. BEHLING:** Mark?

20 **MR. GRIFFON:** You want to go back again?

21 **MS. BEHLING:** I'm sorry. Just to capture
22 everything --

23 **MR. GRIFFON:** Yeah.

24 **MS. BEHLING:** -- 28.19 --

25 **MR. GRIFFON:** Okay.

1 **MS. BEHLING:** -- here again, I just want to be
2 sure that that does get captured then in the
3 site profile.

4 **MR. GRIFFON:** Right. And I think --

5 **MS. BEHLING:** Is that going to take --

6 **MR. GRIFFON:** TK-- TKBS. Right?

7 **MS. BEHLING:** Yes, Savannah River.

8 **MR. GRIFFON:** Yeah. So that, by definition, is
9 caught in the site profile.

10 **MS. BEHLING:** Okay, I --

11 **MR. GRIFFON:** Understand that Stu's got to make
12 sure we're tracking --

13 **MR. HINNEFELD:** What -- which number are we
14 talking about?

15 **MS. BEHLING:** All right, 28.19 --

16 **MR. GRIFFON:** Twenty-eight point nineteen.

17 **MS. BEHLING:** -- and 28.20.

18 **MR. GRIFFON:** There's a action --

19 **MS. BEHLING:** I just don't want to lose those.

20 **MR. GRIFFON:** Right. No, I agree. It's the
21 same thing as before.

22 **UNIDENTIFIED:** Photon and electron.

23 **MR. HINNEFELD:** Oh, it's ambient photon at
24 Savannah River, right.

25 **MR. GRIFFON:** Got to make sure you -- might go

1 in the site profile. Got them there.

2 **MR. HINNEFELD:** Yep.

3 **MR. GRIFFON:** Then we're on to 30, if -- I'll
4 pause while you look through 29.

5 **DR. BEHLING:** There's nothing in 29.

6 **MR. GRIFFON:** Thirty is what -- a case from
7 what site? It's from Hanford. Hanford.
8 Right?

9 **UNIDENTIFIED:** Hanford site.

10 **MR. GRIFFON:** Yeah.

11 **MS. BEHLING:** Okay.

12 **MR. GRIFFON:** So I -- this is a workbook issue
13 and a site profile I guess, really. So there's
14 kind of -- this -- this issue's been deferred
15 to the --

16 **MS. BEHLING:** To the Task III workbook review.

17 **MR. GRIFFON:** Or the site profile review.
18 Right?

19 **MS. BEHLING:** Both.

20 **MR. GRIFFON:** Yeah.

21 **MS. BEHLING:** Yes.

22 **MR. GRIFFON:** Okay. And the same on the next,
23 30.2. And we're down to 30.4, you have a DR
24 general one.

25 **MR. HINNEFELD:** That goes all back -- all the

1 way back to the first matrix.

2 **MR. GRIFFON:** Right.

3 **MR. HINNEFELD:** The first 20 matrix.

4 **MR. GRIFFON:** Okay. This -- and this involves
5 rever-- revising the DR report format. Right?

6 **MR. HINNEFELD:** Yes.

7 **MR. GRIFFON:** So there's a couple of those.
8 Several with no actions -- 30.9 I just edited
9 your response there in yellow. I think you
10 meant to put LOD over two. It's another --
11 it's in the other matrices that way, before it
12 had said LOD.

13 **MR. HINNEFELD:** Yeah. Okay. Should be LOD
14 over two.

15 **MR. GRIFFON:** Right.

16 **MS. MUNN:** Which number?

17 **MR. GRIFFON:** Thirty point nine -- finding
18 30.9.

19 **MR. HINNEFELD:** I did bring this e-mail where I
20 -- (unintelligible) attach to change
21 management, if you're interested.

22 **MS. MUNN:** LOD over two?

23 **MS. BEHLING:** Yeah.

24 **MR. GRIFFON:** Yeah. I mean I guess we should
25 have that. Yeah, that would be good.

1 **MS. MUNN:** LOD over two?

2 **MS. BEHLING:** Uh-huh.

3 **MR. GRIFFON:** Oh, you brought a hard copy of
4 that one. Okay.

5 **MR. HINNEFELD:** Yep.

6 (Pause)

7 **MR. HINNEFELD:** Ray, here's another one. Send
8 that on around.

9 **MR. GRIFFON:** Is this the same thing or...

10 **MR. HINNEFELD:** Yeah.

11 **MR. GRIFFON:** Yeah.

12 **MR. HINNEFELD:** Says finding -- finding 30.9,
13 the copy was just -- we inadvertently kept two
14 over here.

15 **MR. GRIFFON:** So help us out here, Stu -- what
16 -- what are we looking at?

17 **MR. HINNEFELD:** Okay. This -- the front is the
18 e-mail string that documents the timing of the
19 conversation. The back form is an ORAU change
20 management form, which -- when we tell them you
21 can do something one way, we want you to do it
22 a different way -- as a general rule, they put
23 it -- they document that direction to them in
24 this fashion. They prepared this form, and so
25 this is the one we conveyed over -- I hope I

1 got the right one, yeah, LOD over 2 -- and said
2 yes, in fact we want you to behave that way.

3 **MS. BEHLING:** Okay.

4 **MR. GRIFFON:** Okay.

5 **MR. MAHER:** And that's scheduled for
6 implementation the first of September.

7 **MS. MUNN:** Who said that?

8 **MR. HINNEFELD:** That was Ed Maher.

9 **MR. MAHER:** That's because it requires a tools
10 change.

11 **MR. HINNEFELD:** Right.

12 **MR. GRIFFON:** Okay. Thank you. All right,
13 we're up to 30 -- the end of case 30. Look
14 through all those -- everybody set with those
15 'cause I think we're -- we're ready to break
16 for lunch. And as Lew said, we have to switch
17 rooms so I think we should sti-- stick to our
18 12:30 lunch break here.

19 **DR. WADE:** As I mentioned, there's someone
20 outside the door.

21 **MR. GRIFFON:** Does anybody have anything else
22 on 30? Otherwise, we're ready to close for
23 lunch.

24 (No responses)

25 Okay, I think we'll --

1 **DR. WADE:** What time back?

2 **MR. GRIFFON:** Yeah, we'll come back at 1:30,
3 resume the meeting at 1:30.

4 **DR. WADE:** Okay, 1:30. Dial back in. We'll be
5 back.

6 (Whereupon, a recess was taken from 12:30 p.m.
7 to 1:35 p.m.)

8 **UNIDENTIFIED:** (Unintelligible) with ORAU is
9 here.

10 **DR. WADE:** Okay.

11 **MS. GARRISON:** This is Deb Garrison. This is -
12 - this is the party.

13 **DR. WADE:** Well, thank you for joining us.
14 Anyone else?

15 **MR. MAHER:** Ed Maher.

16 **DR. WADE:** Okay. Anyone else?

17 (No responses)

18 Okay, thank you. We'll begin in a moment.

19 **MS. MUNN:** No Mike yet.

20 **MR. GRIFFON:** Okay, everyone on the phone,
21 we're starting off back on the second set of
22 case matrix. And we're on case number 31, I
23 believe. And the first thing I have is --
24 well, let's look at 31.1, actually. This is
25 the DCF equal to one issue -- right, Kathy? --

1 that you were discussing earlier?

2 **MS. BEHLING:** Yes. Yes, we discussed
3 (unintelligible).

4 **MR. GRIFFON:** So just to point that out, that's
5 -- that's going to be carried through.

6 **MS. BEHLING:** Okay.

7 **MR. GRIFFON:** And is that in response to
8 modifying a particular procedure, or is this --

9 **MS. BEHLING:** Well --

10 **MR. HINNEFELD:** It's a -- it's a recurring
11 comment --

12 **MR. GRIFFON:** Right.

13 **MR. HINNEFELD:** -- from dose reconstruction
14 reviews, and apparently number six, initially.

15 **MS. BEHLING:** This actually tied back, I
16 thought, to the Implementation Guide -- the
17 external Implementation Guide for counting for
18 photon doses (unintelligible) critical
19 (unintelligible).

20 **MR. HINNEFELD:** Well, there -- there's - IG-1
21 is where we describe how to do it.

22 **MS. BEHLING:** Right.

23 **MR. HINNEFELD:** So if we think that fits, we'll
24 -- we'll take care of it. Uncertainty -- but
25 this is a kind of subset of that question of

1 uncertainty.

2 **MS. BEHLING:** It is. Yes.

3 **MR. HINNEFELD:** So we -- this is a specific
4 analysis which we're almost done with.

5 **MR. GRIFFON:** That's what I thought, okay.

6 **MS. BEHLING:** Okay.

7 **MR. GRIFFON:** All right. Going on to 31 -- or
8 32, actually -- 32.1 --

9 **MS. BEHLING:** Can --

10 **MR. GRIFFON:** Or the general one you want to
11 look at? Yeah.

12 **MS. BEHLING:** Got to go already. But -- can I
13 just go back to 31.2?

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

15 **MS. BEHLING:** I know this, again, has to do
16 with revising the dose reconstruction wording.
17 Oh, I guess I'm cur-- did you say you have a
18 draft in mind for that dose reconstruction
19 wording? Because --

20 **MR. HINNEFELD:** I have a draft on my desk.

21 **MS. BEHLING:** Okay, 'cause in this particular
22 case we're referring specifically to the fact
23 that -- I guess -- we misinterpreted how many
24 missed photon doses were actually calculated
25 here, and so they said that they were going to

1 try to make the dose reconstruction report --
2 am I interpreting this correctly?

3 **MR. HINNEFELD:** The way the response is written
4 -- what I think what the finding said was the
5 DR says the maximum dose missed is such and
6 such, but the numbers didn't work out, you
7 know. And the -- and it was --

8 **MS. BEHLING:** Right.

9 **MR. HINNEFELD:** -- to me it was the structure
10 -- it was the language that was chosen in the
11 dose reconstruction report to describe --

12 **MS. BEHLING:** That's it. Yes. Okay.

13 **MR. HINNEFELD:** -- so -- and that's why we
14 think we can clarify it with a language change.

15 **MS. BEHLING:** Okay. That's right. That's --
16 now I know the issue. Okay.

17 **MR. HINNEFELD:** Okay.

18 **MS. BEHLING:** But that is being taken care of
19 in the re-write or the -- whatever changes.

20 **MR. HINNEFELD:** Yeah, we think -- we think
21 we're saying it better now --

22 **MS. BEHLING:** Okay.

23 **MR. HINNEFELD:** -- than we were when this dose
24 reconstruction was written --

25 **MS. BEHLING:** Okay.

1 **MR. HINNEFELD:** -- but we are still going to
2 take care of it in that new format.

3 **MR. GRIFFON:** Thirty-two point one.

4 **MS. MUNN:** OTIB-10 has been (unintelligible).

5 **MR. GRIFFON:** Has been revised.

6 **MS. MUNN:** Has been revised.

7 **MR. GRIFFON:** I'm not exactly sure why I
8 highlighted this one in this case, but -- is
9 there a particular reason I highlighted that
10 one, Kathy?

11 **MS. BEHLING:** I'm not sure.

12 **MR. GRIFFON:** Help me out.

13 **MS. BEHLING:** I know, I'm looking at it, too.
14 I -- I'm not sure, 32.1.

15 **MR. GRIFFON:** Was it a question of --

16 **MS. BEHLING:** It's the same -- it's the same
17 issue.

18 **MR. GRIFFON:** Yeah, it's a TIB-10 issue though.
19 Right?

20 **MS. BEHLING:** Yes.

21 **MR. GRIFFON:** It wasn't a question there --
22 okay. I think it's -- I think we're okay with
23 that.

24 **MS. BEHLING:** We're okay.

25 **MS. MUNN:** It's done now.

1 that -- it was worded differently.

2 **MR. HINNEFELD:** Okay. I like this wording,
3 actually.

4 **MR. GRIFFON:** Well, ba-- thank you. Basically
5 in your -- in your action you said that in this
6 case the efficiency approach was justified --

7 **MR. HINNEFELD:** Uh-huh.

8 **MR. GRIFFON:** -- but the prior response didn't
9 say that.

10 **MR. HINNEFELD:** Right.

11 **MR. GRIFFON:** So I said we-- we've got to be
12 consistent.

13 **MR. HINNEFELD:** Right.

14 **MR. GRIFFON:** It was just a consistency thing.

15 **MR. HINNEFELD:** Yes. Thanks.

16 **MR. GRIFFON:** So is that okay? Are we up to
17 that point, too, Kathy?

18 **MS. BEHLING:** Yes. Yes.

19 **MR. GRIFFON:** Okay. I'm freezing. All right.
20 Chocolate has been delivered to Wanda, and
21 we're all set --

22 **MS. MUNN:** Calm will now prevail.

23 **MR. GRIFFON:** Thirty-four point four, Proc -- I
24 -- I added an action that SC&A will review Proc
25 60 --

1 **MS. BEHLING:** Yes.

2 **MR. GRIFFON:** -- in this action column. Not a
3 NIOSH action, but -- okay. Same thing for the
4 next one.

5 **MS. MUNN:** Where did you add that?

6 **MR. GRIFFON:** In the final column.

7 **MR. HINNEFELD:** Thirty-four dot -- 34.4.

8 **MR. GRIFFON:** I'm sorry -- 34.4 and 5,
9 actually.

10 **MS. MUNN:** So you -- so it now reads --

11 **MR. GRIFFON:** SC&A will review Proc 60.

12 **MS. MUNN:** Oh, okay.

13 **MR. GRIFFON:** Yeah, that's all.

14 **MS. MUNN:** Yeah, that's --

15 **MR. GRIFFON:** It was already in there.

16 **MS. MUNN:** -- what it says, yeah.

17 **MR. GRIFFON:** Any questions on 34.6, Kathy, or
18 these -- these specific NIOSH findings -- or
19 actions, I mean?

20 **MS. BEHLING:** Okay, you know, this is fine.

21 **MR. GRIFFON:** These are fine. Right? Yeah --
22 I just wanted to pause.

23 **MS. BEHLING:** Yes. That's appropriate.

24 **MR. GRIFFON:** Okay. I'm panning down to 36.1.
25 I gue-- I'll wait to make sure.

1 **MS. BEHLING:** Just one second.

2 **MR. GRIFFON:** Yeah.

3 **MS. BEHLING:** Okay, yes.

4 **MR. GRIFFON:** I think we're okay on that.

5 **MS. BEHLING:** Yes.

6 **MR. GRIFFON:** So 36.1 --

7 **MS. BEHLING:** Okay, let me be sure. This is
8 the issue where this document right here that's
9 attached to a lot of the --

10 **MR. GRIFFON:** Is this the Hanford? Yeah, yeah
11 --

12 **MS. BEHLING:** -- Hanford cases --

13 **MR. GRIFFON:** -- this is the Hanford. Right.

14 **DR. BEHLING:** (Unintelligible) hard copy DOE
15 records.

16 **MS. BEHLING:** Right. And --

17 **DR. BEHLING:** And the binder with a -- an
18 explanation.

19 **MS. BEHLING:** Right. They provide an
20 explanation of how they deal with various doses
21 for various years -- for assigning various
22 doses and -- and shallow dose specifically.
23 And they have two tables and these --

24 **MR. GRIFFON:** This is in every case file for
25 Hanford, basically. Yeah, yeah.

1 **MS. BEHLING:** Yes.

2 **MR. GRIFFON:** Yeah.

3 **MS. BEHLING:** And so this becomes an issue that
4 we'll have to deal with, I think -- that we
5 have to talk to the Hanford DOE about because
6 the two tables have conflicting data --
7 conflicting information on them as to how to
8 treat shallow dose. At least based on how we
9 read it. I think table one and table two --

10 **MR. HINNEFELD:** Okay, I didn't attach table
11 one, I only attached -- oh wait, there they
12 are. There it is.

13 **MR. GRIFFON:** Table one and two at the back of
14 Stu's handout.

15 **MS. BEHLING:** And --

16 **MR. HINNEFELD:** Are those the table one and two
17 we're talking about? Or have I mixed and
18 matched table one and two -- did not -- didn't
19 include all of table one?

20 **MR. GRIFFON:** Yeah, I don't know if they're the
21 same.

22 **MS. BEHLING:** This is -- oh, you have -- you
23 have something for this.

24 **MR. GRIFFON:** Yeah, it is. It the same.

25 **MR. HINNEFELD:** Uh-huh.

1 **MS. BEHLING:** I'm sorry.

2 **MR. HINNEFELD:** Okay, that is what I handed
3 out, right.

4 **MR. GRIFFON:** Yeah.

5 **MS. BEHLING:** Okay, it is.

6 **MR. GRIFFON:** So we want to -- basically as an
7 action, we thought --

8 **MR. HINNEFELD:** What -- what I want to do is
9 talk about --

10 **MR. GRIFFON:** Okay, you can --

11 **MR. HINNEFELD:** -- what my understanding --

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

13 **MR. HINNEFELD:** -- of this dosimetry record
14 that we have and the two -- there is, let's see
15 -- there are, again, two renditions of the
16 exposure record there in my package, the --
17 what I handed out. The third and fourth page
18 are two separate renditions of the exposure
19 record. The -- in the table, the era we're
20 talking is 1980 and 1981. That's when the
21 doses were recorded for this person. And so on
22 table two, you look and see this -- this two-
23 sided table appears that -- is saying that.
24 But on the left-hand column it gives the
25 dosimeter components of the dosimeter badge.

1 In other words, they had a component that read
2 non-penetrating photons, penetrating photons,
3 slow neutron and fast neutron, so those were
4 the neutron components.

5 Now on the right-hand column it describes how
6 are those components used to develop the skin
7 and the -- and the whole body doses. So the
8 whole body dose is comp-- is the components --
9 you know, the combination of the penetrating
10 photon, slow neutron and fast neutron
11 component. And the skin dose is the whole body
12 component -- in other words, all that stuff you
13 just added -- plus the shallow photon
14 component. Non-penetrating. Plus the non-
15 penetrating component.

16 **MR. GRIFFON:** Yeah.

17 **MR. HINNEFELD:** Okay? So -- all right, I'm
18 reading from -- I'm reading from '72 because I
19 believe these dates are the date of change. So
20 the '72 rules would last up through '80 and
21 '81, all the way to '87.

22 **MS. BEHLING:** That's right.

23 **MR. HINNEFELD:** Okay? All right. Now on the
24 renditions of the exposure report, which appear
25 to be the same, the values that are reported in

1 -- on one are whole body and skin -- external
2 whole body and skin -- and that seems to match
3 with what they've reported in table two, or in
4 the se-- right-hand column of table two they
5 report whole body and skin. So if you look at
6 the values for whole body and skin -- this
7 would be on the first rendition of the
8 attachment -- the difference between the 40 and
9 the ten is the non-penetrating component of the
10 dosimeter badge, the non-penetrating
11 components' contribution --

12 **MR. GRIFFON:** Right.

13 **MR. HINNEFELD:** -- based on -- on this table.
14 And so that's the difference then between a
15 non-penetrating exposure to the badge and the
16 penetrating photon exposure. And so that's the
17 difference that's the starting point of the
18 shallow dose calculation. And I believe the DR
19 was done in that fashion.

20 **MR. PRESLEY:** In other words, you're -- you're
21 saying that there was a calculation made to --
22 to bring that level up for skin that would
23 allow for some type of a -- of a-- some piece
24 of --

25 **MR. HINNEFELD:** That --

1 **MR. PRESLEY:** -- right -- plastic or something?

2 **MR. HINNEFELD:** What I'm saying -- yeah, the
3 skin dose -- what's reported as the skin dose
4 already includes the penetrating dose, and then
5 the skin is additional to that.

6 **MR. PRESLEY:** Uh-huh.

7 **MR. HINNEFELD:** So it's not -- so you wouldn't
8 -- in developing the skin dose you wouldn't
9 take the non-penetrating -- or you wouldn't
10 take the skin and whole body totals and add
11 them together from the back.

12 **MR. PRESLEY:** Right.

13 **MR. HINNEFELD:** But it would be -- but the non-
14 penetrating dose, or the skin dose, would be
15 the difference between what's reported as whole
16 body and what's reported as skin.

17 **MR. MAHER:** This is the clerk of the Hanford
18 records.

19 **MR. HINNEFELD:** That was Ed Maher again. Yes.
20 It's not -- and we did agree with the comment,
21 and one part of the comment was the Hanford
22 records were confusing, and we certainly did
23 agree with that part of the comment.

24 **MS. MUNN:** But they're consistent records.

25 **MR. HINNEFELD:** Yeah.

1 **MS. MUNN:** Once you know what to do, I mean.

2 **MR. GRIFFON:** Well, then -- back to your
3 original, Kathy, on these tables being
4 inconsistent.

5 **MS. BEHLING:** Well, yeah, that's what I thought
6 we had looked here. But I -- I have to -- I
7 have to go back and think about this one.

8 Because I think it had something to do with --

9 **DR. BEHLING:** Where does table three come from?

10 **MS. BEHLING:** This is our table.

11 **MR. GRIFFON:** Yeah. And table -- Stu, in your
12 handout table three is the same as the other
13 table two?

14 **MS. BEHLING:** Table three is --

15 **MR. GRIFFON:** There's like something in there
16 called table three.

17 **DR. BEHLING:** And I think this comes from the
18 TBD.

19 **MR. GRIFFON:** And then it's a different version
20 of table two, isn't it?

21 **DR. BEHLING:** Yeah, and I think this is where
22 the problem came in.

23 **MR. HINNEFELD:** Okay, so it's inconsistent
24 between table two and three, then?

25 **MR. GRIFFON:** Maybe, I don't know. That's --

1 that's -- I'm not sure.

2 **MS. BEHLING:** Yeah, --

3 **MR. HINNEFELD:** Table three comes from the TBD?

4 **DR. BEHLING:** And your second page is -- is a
5 table three, and I think that comes out of --

6 **MR. GRIFFON:** From the TBD?

7 **DR. BEHLING:** -- from the TBD.

8 **MR. GRIFFON:** Yeah. And the other one's in the
9 DR file.

10 **DR. BEHLING:** Yes.

11 **MR. GRIFFON:** And you're saying they might be
12 incon-- I think we might need time. And I
13 don't know if we can do this real time, but --

14 **MR. HINNEFELD:** Well, from '72 to '94 period it
15 looks to be the same. Right? That table just
16 summarizes --

17 **MR. GRIFFON:** Yeah.

18 **MS. BEHLING:** Yeah, it does.

19 **MR. HINNEFELD:** -- it's -- it's a different
20 date grouping.

21 **MS. BEHLING:** Yeah.

22 **MR. HINNEFELD:** It's a different date grouping
23 than table two, but it seems to say the same
24 things that I just said about that period. And
25 we didn't check -- I haven't checked all these

1 other date periods in that because I'm -- maybe
2 I misunderstood the nature of the comment.

3 **MS. BEHLING:** (Unintelligible) because here, in
4 this table, shallow (unintelligible) -- the
5 records -- I don't know.

6 **MR. GRIFFON:** Here -- here's what I propose is
7 we leave that initial finding 3-- or action
8 36.1. Stu, you -- you've given us a respon--
9 you know, a response toward that end, I think.
10 Your DR 36.1 --

11 **MR. HINNEFELD:** Sure.

12 **MR. GRIFFON:** -- and let's delete the
13 highlighted yellow section at this point. And
14 after further review, if -- if Hans and Kathy
15 feel like there is an inconsistency, then we'll
16 add that on in our --

17 **MS. BEHLING:** Yeah. I'll -- I'll let you know
18 about that. For some reason I thought there
19 was.

20 **MR. GRIFFON:** -- but the path forward will --
21 will hinge on your first action. Okay, Stu?
22 Is that --

23 **MR. HINNEFELD:** Okay. Okay.

24 **MR. GRIFFON:** So I'm deleting that bottom
25 section of the action.

1 **DR. BEHLING:** Yeah, I -- I think the issue
2 really comes into play when you look at the
3 actual records themselves, which are defined in
4 -- in -- different terms, where you really are
5 given a shallow dose, a deep dose, a neutron,
6 (unintelligible), et cetera. And then when you
7 just kind of go through the identification of
8 those values and -- without necessarily going
9 through the exercise -- you would tend to come
10 with some -- up with some questionable
11 conclusions out of -- by the table methods in
12 table two or table three. It's just somewhat
13 confusing. I think in the end you may be
14 right. As -- if you go through the full
15 exercise and going over and identifying each of
16 the components that are defined as shallow or
17 deep, you will probably end up with the right
18 number.

19 **MR. GRIFFON:** Let's -- let's just leave it
20 there and you --

21 **MS. BEHLING:** Yeah.

22 **MR. GRIFFON:** -- it'll give you time to -- to
23 look at those again. It's -- you know.
24 Thirty-six point two has this -- I highlighted
25 the DCF-1 issue. Prior to this we had had it

1 as an action, I think. Right? So I did--
2 didn't know.

3 **MR. HINNEFELD:** Well, I -- it was a comment I
4 threw in --

5 **MR. GRIFFON:** Yeah.

6 **MR. HINNEFELD:** -- because it -- you know, one
7 of -- part of the comment was if it's skin dose
8 you shouldn't use the DCF but use a DCF of one.
9 And using DCF of one is the same
10 (unintelligible) as DCF.

11 **MR. GRIFFON:** Right.

12 **MR. HINNEFELD:** So I just threw that comment
13 in.

14 **MR. GRIFFON:** Yeah.

15 **MR. HINNEFELD:** It can be taken out.

16 **MR. GRIFFON:** Yeah. No, I mean I'll -- I'll
17 just un-highlight it. It's fine.

18 **MR. HINNEFELD:** Yeah.

19 **MR. GRIFFON:** Kathy, Hans, are we moving forwa-
20 - are you?

21 **MS. BEHLING:** Yes. Yes.

22 **MR. GRIFFON:** Look at that later. I -- I think
23 we'll look -- yeah.

24 **MS. BEHLING:** Sorry.

25 **MR. GRIFFON:** It's a continued action. I don't

1 want to lose the other --

2 **MS. BEHLING:** Okay.

3 **MR. GRIFFON:** So I'm on 36.7. I don't have
4 anything highlighted here but I just wanted to
5 make sure that Kathy and Hans didn't have
6 anything.

7 **MR. HINNEFELD:** Thirty-six seven, eight and
8 nine kind of go together.

9 **MR. GRIFFON:** Yeah. Okay.

10 **MS. BEHLING:** Okay. Is this the case where the
11 individual worked at Y-12 and K-25?

12 **MR. GRIFFON:** No.

13 **MR. HINNEFELD:** No, this one is the guy who
14 scratched his face and...

15 **MS. BEHLING:** Oh, okay. Yeah. You resolved
16 that. I think you resolved that.

17 **MR. GRIFFON:** Yes.

18 **MR. HINNEFELD:** Yeah. We -- I've got copies of
19 our additional request and our responses --

20 **MS. BEHLING:** Yes.

21 **MR. HINNEFELD:** -- if anybody wants them.

22 **MS. BEHLING:** I think that's resolved based on
23 those records.

24 **MR. GRIFFON:** Well, "there's no further action"
25 is what's on there right now. Right? For

1 36.7, yeah, yeah.

2 **MR. HINNEFELD:** What I'm saying is that we've
3 done what we -- you know, at the last -- at the
4 last meeting, said this is a fairly recent, you
5 know, there -- there might be first aid
6 records, and the --

7 **MS. BEHLING:** That's right.

8 **MR. HINNEFELD:** -- the response form, the
9 original response from Hanford didn't have
10 anything checked when he got the incident. It
11 didn't say present, didn't say non-valid --
12 didn't say anything --

13 **MS. BEHLING:** That's right.

14 **MR. HINNEFELD:** -- nothing was checked. So we
15 went back and asked. We asked again, hey,
16 specifically for this -- this particular case,
17 do you have any acci-- any incident or first
18 aid information? And they looked for more than
19 just the year we specified. They looked for
20 several years and in two different record
21 cabinets. And they didn't find anything. And
22 this time they did -- when they responded --
23 they did check either "not available or does
24 not exist" to provide -- but they did make the
25 check on their most recent response.

1 **MS. BEHLING:** Okay.

2 **MR. HINNEFELD:** I -- I've included both their
3 original cover sheet and their second cover
4 sheet.

5 **DR. BEHLING:** And that was really all our
6 recommendation was, just to verify that there
7 was -- there were no records that suggest that
8 there -- such an injury ever took place.

9 **MR. HINNEFELD:** Right. And so we did pursue
10 that.

11 **MS. BEHLING:** Okay.

12 **MR. GRIFFON:** The next two, 36.8 and 9, I'm
13 going to delete that second part because we've
14 discussed it in the procedures review. Right?
15 That's what I said earlier, it's the CATI
16 question.

17 **MR. HINNEFELD:** Yeah.

18 **MS. BEHLING:** Uh-huh, this is --

19 **MR. GRIFFON:** Thirty-six point eight and 36.9.

20 **MS. MUNN:** Eight and nine. The highlighted
21 stuff comes out. Right?

22 **MR. GRIFFON:** It's in the procedures review,
23 correct.

24 **MS. MUNN:** Yeah.

25 **MR. GRIFFON:** All right. And that concludes

1 the second matrix, I think. Everybody
2 satisfied with that?

3 **MS. BEHLING:** Uh-huh.

4 **MR. GRIFFON:** Wow, are we good.

5 **MS. MUNN:** (Unintelligible) none, none, none
6 and none. Oh, I like those nones.

7 **MR. GRIFFON:** Nein. Not none. All right.

8 **SUMMARY OF FINDINGS MATRIX: CASES 39 THROUGH 60**

9 Opening up the third set matrix now. Third set
10 of cases titled "Summary of Findings Matrix:
11 Cases 39 through 60." Everybody got that
12 prepared? "July 23rd" it should say on the top
13 -- it's the version.

14 **MS. BEHLING:** Uh-huh.

15 **MR. GRIFFON:** All right, 40.1. Is there -- so
16 this is a -- an evaluation, Stu, that's ongoing
17 on 40.1?

18 **MR. HINNEFELD:** It's one of our actions, right.

19 **MR. GRIFFON:** Right, okay. I didn't know if
20 you had a related handout.

21 **MR. HINNEFELD:** No. That's (unintelligible).

22 **MR. GRIFFON:** Okay, 41.1. This is the CATI
23 question again, so I think it's going away;
24 42.2 has that action on the "evaluate whether
25 the constant value is bounding," that's the

1 DCF-1 issue?

2 **MR. HINNEFELD:** Yes.

3 **MR. GRIFFON:** Yep. Forty-two point four --
4 yeah, this -- this question was -- "discuss in
5 the site profile review" was in the NIOSH
6 resolution column. And then "none at this
7 time" was the -- so I -- I thought that was
8 inconsistent there. Is the action to discuss
9 this in the NIOSH site profile review?

10 **MR. HINNEFELD:** This -- well, it could be drawn
11 into the earlier discussion we had where we
12 talked about the OCAS-TIB that talked about
13 assigning neutron doses at Savannah River,
14 'cause that's the question here. This was a
15 Savannah River worker. And the question was
16 raised -- maybe this guy should be assigned
17 neutrons, having worked there -- because he
18 worked for -- the entirety was before 1971 when
19 TLD badging got -- when they started using TLDs
20 and neutron monitoring kind of got a little
21 more reliable at Savannah River. And so, what
22 about this guy who's an iron worker? And this
23 particular employee has an extensive bioassay
24 record. And the advantage of the bioassay
25 record in this case is it has a work location

1 on it. The majority of this person's bioassays
2 were collected under the abbreviation CS, which
3 is central shops, in the 700 area -- which --
4 where you would not expect to have a neutron
5 exposure to an iron worker. He was in the
6 reactor area, and some of his bioassay was in
7 the -- it would say C or K or P and so he'd be
8 in the reactor area for some of it. And so the
9 is-- the question -- and I -- the way we get
10 into the site profile or into the OCAS-TIB
11 about neutron exposures is is the guidance
12 sufficient -- is it sufficient so that it was
13 applied correctly and is being applied
14 correctly to people like this. My own reading,
15 which is not necessarily the expert reading
16 because I -- I was doing it to prepare for
17 this, it's not exactly like I know this exactly
18 off the top of my head, is this -- this seems
19 to be like an okay selection. You know, the
20 selection that this guy -- if he was ex--
21 exposed to neutrons, it would have been sort of
22 incidental and not -- not really much to it --
23 came from the fact that he generally seemed to
24 work out of central shops. So he would have
25 been in a number of places rather than in the

1 reactor building. In the reactor -- in the
2 reactor facilities there are some jobs where we
3 do want to include neutron exposure if they
4 worked in a crane bay -- the maintenance in the
5 crane bay, so --

6 **MR. GRIFFON:** Now I don't -- I don't know
7 enough about Savannah River and how they
8 outsourced maintenance people, but I know some
9 facilities certainly you would have been out of
10 the central shops but you would have done a lot
11 of work --

12 **MR. HINNEFELD:** Well, he certainly would have
13 worked all over the plant.

14 **MR. GRIFFON:** Right.

15 **MR. HINNEFELD:** That's for sure.

16 **MR. GRIFFON:** But -- but not in the reactor
17 buildings?

18 **MR. HINNEFELD:** He was assigned. He worked in
19 the reactors. But in the reactors, the neutron
20 -- the people who were neutron-exposed,
21 according to our OTIB -- or R-TIB, not an OTIB;
22 not an OCAS-TIB -- according to that it's --
23 it's not everybody in the reactor areas.
24 There's, you know, people working maintenance
25 in the crane bays and there's a certain number

1 of construction-type job titles -- or
2 maintenance-type job titles listed there. Iron
3 worker was not one of them. But maybe iron
4 worker should be.

5 **MR. GRIFFON:** Right.

6 **MR. HINNEFELD:** And then perhaps operators and
7 (unintelligible) control technicians. Those
8 are the people who were likely in the crane bay
9 while the reactors were running. Most other
10 people in the reactors don't really -- didn't
11 really have a lot of potential for neutron
12 exposure, according to our TIB. So the
13 question, I think, about whether this case was
14 done correctly relates to is the guidance for
15 selecting the people who are potentially
16 neutron-exposed -- is that good enough? Is
17 that good guidance? And which wraps up into
18 Savannah River and TIB combination questions.
19 So that's why I thought it would be best
20 disposed of in the Savannah River site profile.

21 **MR. GRIFFON:** Okay. Well, I'm in agreement
22 with that. I just noticed that there was no
23 action in your action column.

24 **MR. HINNEFELD:** Oh, I was tired that day.

25 **MR. GRIFFON:** Okay. So I -- the -- the next

1 two I would propose just moving over my
2 resolution into the action also, "discuss in
3 the site profile review."

4 **MR. HINNEFELD:** Yeah. Yeah.

5 **MR. GRIFFON:** And you want me to number these
6 as 42.4 -- DR 42.4?

7 **MR. HINNEFELD:** Sure. Now 43.1 is a different
8 case.

9 **MR. GRIFFON:** Oh, okay -- yeah, you're right.
10 But it was -- that's right. I thought that was
11 the same case. I'm sorry. Well, this one is
12 4-- DR -- it'd be DR --

13 **MR. HINNEFELD:** This would be DR 42.4.

14 **MR. GRIFFON:** -- 42.4 as an action.

15 **MR. HINNEFELD:** Yeah.

16 **MR. GRIFFON:** And it's just to "discuss further
17 in the site profile review."

18 **MS. BEHLING:** Uh-huh.

19 **MR. GRIFFON:** And the next one is -- Stu is
20 correct, it's 43.1, a different case. So is
21 this --

22 **MS. BEHLING:** This is -- excuse me, Mark, I'm
23 sorry. This was a finding that we just added -
24 -

25 **MR. GRIFFON:** That's right.

1 **MS. BEHLING:** -- based on our discussions --
2 **MR. GRIFFON:** This is the K-K-25 one? Yeah.
3 **MS. BEHLING:** No.
4 **MR. GRIFFON:** No?
5 **MS. BEHLING:** This is still not K-25.
6 **MR. GRIFFON:** Okay.
7 **MS. BEHLING:** This is Y-12. But we just --
8 **DR. MAURO:** A coworker.
9 **MS. BEHLING:** Yeah, this was another coworker
10 issue, and we just added this based on our last
11 --
12 **MR. GRIFFON:** Right.
13 **MS. BEHLING:** -- working group meeting.
14 **MR. HINNEFELD:** Is this the Y-12 --
15 **DR. MAURO:** The pre-'61 coworker problem.
16 **MR. HINNEFELD:** Okay, we didn't use that for
17 this 'cause they had exposure records pre-'61.
18 Here, I got -- I've got them --
19 **MR. GRIFFON:** Yeah, this matrix -- you were
20 working off --
21 **MR. HINNEFELD:** I was working off the previous
22 matrix.
23 **MR. GRIFFON:** Right.
24 **MR. HINNEFELD:** But I did look at yours.
25 **MR. GRIFFON:** So this was -- it was sort of in

1 that matrix, Stu. It was in -- part of the
2 resolution column it said "add finding 43.1" or
3 something like that. So this is more or less -
4 -

5 **MR. HINNEFELD:** This case --

6 **MR. GRIFFON:** -- more or less new, I think.

7 **MR. HINNEFELD:** Yeah, this case didn't use the
8 pre-'61 photon coworker model. We used a pers-
9 - this individual's exposure records.

10 **MR. GRIFFON:** Oh, okay.

11 **MR. HINNEFELD:** This -- this is this claimant's
12 exposure records.

13 **MR. GRIFFON:** Oh, okay.

14 **MR. HINNEFELD:** Now clearly the pre-'61 photon,
15 you know, coworker issue is on the table in Y-
16 12.

17 **MR. GRIFFON:** Why do we -- yeah.

18 **DR. MAURO:** But didn't go to that year.

19 **MR. HINNEFELD:** But this -- well, this -- this
20 guy was ba-- badged. He was badged in '54 when
21 he started working.

22 **DR. MAURO:** So he's one of those few percent --

23 **MR. HINNEFELD:** One of those few percent that
24 were badged.

25 **UNIDENTIFIED:** (Unintelligible) and this is him

1 here.

2 **MR. HINNEFELD:** Uh-huh. Yeah, I had to take
3 off the -- the identifier, but if you look up -
4 - you have access to the record -- you know,
5 you look up this guy, this is in his DOL
6 response -- DOE response.

7 **MR. GRIFFON:** So a coworker model was not --
8 applied here.

9 **MR. HINNEFELD:** A coworker model was not used
10 for this case.

11 **DR. MAURO:** I seem to forget now, but for pre-
12 '61 when you do have data for those two percent
13 to 20 percent over that time period where you
14 have data -- external data -- I guess I wasn't
15 quite sure whether you always went to the
16 coworker model or you actually used that --

17 **MR. HINNEFELD:** Well, that's a good point. If
18 -- if his exposure record would penalize him
19 compared to the coworker model, we would use
20 the coworker model.

21 **DR. MAURO:** Ah, I gotcha.

22 **DR. BEHLING:** And only if you were dealing with
23 a maximized dose reconstruction.

24 **MR. GRIFFON:** Right.

25 **DR. BEHLING:** I would assume that if you were

1 doing a best estimate you would use the --

2 **MR. HINNEFELD:** It's been so long I couldn't
3 tell you. I don't really know.

4 **MR. SHARFI:** But you know --

5 **MR. GRIFFON:** I would assume that would be the
6 case.

7 **MR. SHARFI:** I would think we'd be always --
8 we'd default to their -- they have exposure
9 records -- that we'd -- that for best estimate
10 we'd have to use their exposure records.

11 **DR. BEHLING:** Yeah, I mean --

12 **MR. GRIFFON:** Right, right. And that seems to
13 make sense.

14 **DR. BEHLING:** -- regulatory commitments bind
15 you to that. Records always prevail over
16 anything else.

17 **MR. MAHER:** That's right, the hierological
18 (sic) data usage, yeah.

19 **MR. HINNEFELD:** Yeah.

20 **MR. GRIFFON:** Yeah. So what -- I'm trying to
21 figure out 43.1 again. And it was for photon
22 doses so --

23 **MS. BEHLING:** Well, I believe that we were
24 questioning also -- this particular person was
25 a machinist and I think the reason we put it

1 into the site profile review issue is because
2 we were questioning whether -- and -- and I
3 have to say I'm not -- I didn't go back to
4 these records to realize that this person
5 actually had records -- his own records as
6 opposed to coworker data, but I think we were
7 questioning whether coworker data is
8 appropriate for all of the job -- job titles.
9 But he actually may have gone beyond -- based
10 on the work locations, he actually may have
11 gone beyond being a machinist.

12 **MR. GRIFFON:** But he -- it looks like in this
13 case he has dosimetry for all the peri-- all
14 the covered periods. Is that what you're --

15 **MR. HINNEFELD:** He -- yeah, he was one of the
16 few guys. I believe he started working in '54
17 and that's when his exposure record starts, I
18 believe.

19 **MR. GRIFFON:** 'Cause that --

20 **MR. HINNEFELD:** There's another --

21 **MR. GRIFFON:** He didn't work pre-'54, we're
22 pretty sure -- you're sure of that.

23 **MS. BEHLING:** '56 and '57 I believe. And I
24 think what we wrote in here is that we were
25 questioning if the use of the coworker model,

1 which combines dose for all monitored worker --
2 workers, is appropriate for specific groups of
3 workers such as -- you know, in this particular
4 case, I guess this individual -- as we said
5 earlier, they did not use a coworker model, but
6 we're -- we were questioning, I think, if it's
7 appropriate for all specific types of workers -
8 -

9 **MR. HINNEFELD:** Okay, we'll --

10 **MS. BEHLING:** -- and that's why it got referred
11 to the site profile.

12 **MR. HINNEFELD:** That's clearly a Y-- yeah,
13 that's a Y-- that's a site profile
14 (unintelligible).

15 **MR. GRIFFON:** That is a site profile issue --

16 **MR. HINNEFELD:** Yes.

17 **MS. BEHLING:** Okay.

18 **MR. GRIFFON:** -- but I think there's no action
19 here for this.

20 **MS. BEHLING:** Not for this case.

21 **MR. GRIFFON:** Doesn't look like it. Right?
22 Okay. I'm just going to complete the matrix
23 putting no action on that.

24 **MS. BEHLING:** Okay.

25 **MR. GRIFFON:** And also in the resolution I

1 think I'm going to add that for this individual
2 there were -- he had individual dosimetry
3 records. Yeah.

4 **MR. HINNEFELD:** I think this individual may
5 have worked in one of the buildings where
6 thorium was used at Y-12 as well. So it may --
7 the whole case may become -- this pretty good
8 case may become moot.

9 **MS. BEHLING:** That's it. That's it.

10 **MR. GRIFFON:** That's what we -- that's what we
11 were discussing.

12 **MS. BEHLING:** Yes.

13 **MR. GRIFFON:** I knew there was a reason this
14 was in here. Yes, that's what we were
15 discussing.

16 **MS. BEHLING:** Yes. That's it. I couldn't --
17 that's it. Yes.

18 **MR. GRIFFON:** That was why the site profile
19 thing came up.

20 **MS. BEHLING:** Yes.

21 **MR. PRESLEY:** He worked in (unintelligible)?

22 **MR. HINNEFELD:** Ninety-two twelve one?

23 **MR. GRIFFON:** But it's not -- this says
24 assigning photon doses but --

25 **MS. BEHLING:** Yeah.

1 **MR. PRESLEY:** 9201-1?

2 **MR. HINNEFELD:** I can't recall.

3 **MR. PRESLEY:** That's the general machine shop.
4 Most of your thorium work was done in five.

5 **MR. HINNEFELD:** Five?

6 **MR. PRESLEY:** 9201-(unintelligible) --

7 **MR. HINNEFELD:** He has like four or five --

8 **MR. GRIFFON:** You've got to look at a list of
9 buildings, yeah.

10 **MR. HINNEFELD:** -- he has -- he listed about
11 four or five buildings where he worked and I
12 asked Bomber, I said any of these buildings on
13 the list for thorium, and he -- Bomber was
14 pretty sure that they were.

15 **MS. BRACKETT:** He's got chest counts for
16 thorium.

17 **MR. HINNEFELD:** He does have chest counts that
18 include thor-- well --

19 **MR. GRIFFON:** But that was later. Right?

20 **MR. HINNEFELD:** -- chest count's a
21 (unintelligible) amount, though. Right? Or do
22 they only -- do they only record thorium if
23 there's a potential for thorium or did chest
24 counter just spit out that thorium number?

25 **MS. BRACKETT:** No, I believe it was just for

1 people who had the potential, because we've got
2 a coworker study based on those results.

3 **MR. HINNEFELD:** See there, he does have chest
4 counts for thorium.

5 **MR. GRIFFON:** That would have been post --
6 post-'57. Right?

7 **MR. HINNEFELD:** Yeah.

8 **MS. BRACKETT:** Right, it's later on, so...

9 **MR. GRIFFON:** So did he work there earlier is
10 the question, yeah. But -- that really is a
11 separate, though, site profile issue. But that
12 was part of the discussion I think. Yeah. But
13 for photon doses, the -- I'm putting the
14 resolution that he does have individual
15 dosimetry records, and there's no action for
16 this specific case.

17 **MS. BEHLING:** That's right.

18 **MR. GRIFFON:** Is that okay? All right, 43.3,
19 I'll take out that (unintelligible) finding
20 43.1.

21 **MS. BEHLING:** Yes.

22 **MR. GRIFFON:** Now this -- here's the internal
23 part. Right?

24 **MS. BEHLING:** Yes.

25 **MR. GRIFFON:** So this is the -- I think this

1 would involve further discussion in the site
2 profile review. I'm sure it's going to be
3 caught there anyway, but -- right, Stu?

4 **MR. HINNEFELD:** Yeah. Yeah. There's another
5 aspect of this is this person has a pretty
6 complete bioassay record so why did we use TIB-
7 2. You know, that's one aspect of the finding
8 and it probably shouldn't have used --

9 **MR. GRIFFON:** That was before --

10 **MR. HINNEFELD:** -- probably should not have
11 used TIB-2.

12 **MR. GRIFFON:** -- that was before the thorium
13 question came up with the -- yeah.

14 **MR. HINNEFELD:** So in this particular case,
15 chances are that the DR should have been done
16 with an internal dose reconstruction using the
17 bioassay record as opposed to using TIB-2. But
18 the -- but -- the whole -- like I said, the
19 whole case I believe is going to be moot 'cause
20 I did check this guy's diagnosis and I believe
21 that's a specified dose -- pretty sure he has a
22 specified cancer.

23 **MR. GRIFFON:** Okay, I'm going to put DR 43.3,
24 though -- follow up on site profile review? Or
25 does that -- might not make sense?

1 **MR. HINNEFELD:** Well, I think-- well, it can.
2 I mean the internal question is -- is certainly
3 open in -- in site profile and if you want us
4 to try to take a look at a -- you know, we
5 could -- I would prefer not to go do an
6 internal dose assessment using bioassay record
7 on this case --

8 **MR. GRIFFON:** Yeah.

9 **MR. HINNEFELD:** -- if it's -- if it's not going
10 to -- when it's not ever going to go anywhere,
11 because -- you know, so...

12 **MS. BEHLING:** Of course.

13 **DR. MAURO:** The only question is what cancer
14 did he have, if it's covered by the --

15 **MR. HINNEFELD:** I can -- I can confirm that and
16 let you know. I -- I-- in fact, if you've got
17 the DR report it'll say it in the DR review.

18 **DR. BEHLING:** Yeah.

19 **MR. GRIFFON:** You're saying the other part --
20 you're -- the other part we're capturing anyway
21 in the SEC follow up. Right? So we don't need
22 an action on this.

23 **MR. HINNEFELD:** That's listed. Right? Yeah.

24 **MR. GRIFFON:** All right. So then -- then
25 there's no action. Right? For this specific

1 case. Okay.

2 **MS. MUNN:** We can take the site profile review

3 --

4 **MR. GRIFFON:** Right.

5 **MS. MUNN:** -- on the --

6 **MR. GRIFFON:** I'm deleting that, yeah. Forty--
7 44.1 I'm down to.

8 **MS. BEHLING:** This was the individual that
9 worked at Y-12 --

10 **MR. GRIFFON:** Yes.

11 **MS. BEHLING:** -- and K-25.

12 **MR. GRIFFON:** So re-evaluating this case, Stu,
13 is what you're talking about.

14 **MR. HINNEFELD:** Right.

15 **MR. GRIFFON:** And -- is there any other
16 comments on that?

17 **MS. BEHLING:** You haven't done any of that re-
18 evaluation?

19 **MR. HINNEFELD:** We have not done it, no. I
20 will -- I will tell you that -- this one, I do
21 remember a little bit and it has to do -- the
22 guy worked in both Y-12 and K-25 --

23 **MR. GRIFFON:** Right.

24 **MR. HINNEFELD:** Correct? He was a machinist?

25 **DR. BEHLING:** No -- no records for him in K-25.

1 **MR. HINNEFELD:** And no records in K-25. He
2 worked -- the building identified, 1401 at K-
3 25, is the maintenance building.

4 **MR. GRIFFON:** Right.

5 **MR. HINNEFELD:** So he could very well have
6 machined --

7 **MR. GRIFFON:** Anything.

8 **MR. HINNEFELD:** -- contaminated equipment.
9 But he wouldn't have been a uranium machinist,
10 which he appeared to be at Y-12. And so the
11 exposure -- chances are there was no -- maybe
12 there was no monitoring required -- I don't
13 know if anybody can help me out -- at, you
14 know, K-25 in the -- in the machining building
15 or the maintenance building, which would not be
16 one of the production buildings.

17 **MR. GRIFFON:** No, there was -- there was
18 monitoring.

19 **MR. PRESLEY:** Yeah, and they were all monitored
20 --

21 **MR. GRIFFON:** They were all monitored.

22 **MR. PRESLEY:** -- 'cause that's -- you know,
23 that -- that building's --

24 **MR. GRIFFON:** They had every -- yeah -- they
25 were monitored in that.

1 **MR. HINNEFELD:** Okay -- in 1305?

2 **MR. PRESLEY:** Yeah.

3 **MS. BEHLING:** And this was -- this was back in
4 the '60s and early '70s, '65 through '71.

5 **MR. GRIFFON:** I checked that time period and
6 the -- and where he was there should have been
7 monitoring. Okay.

8 **MR. PRESLEY:** Yeah.

9 **MR. HINNEFELD:** Okay. All right.

10 **MR. GRIFFON:** So it's worth following up that
11 --

12 **MR. HINNEFELD:** We may --

13 **MR. MAHER:** Should be something there, Stu.

14 **MR. HINNEFELD:** Yeah.

15 **MR. PRESLEY:** Something (unintelligible).

16 **MR. GRIFFON:** Forty-six point one -- finding
17 46.1 -- the only question I really had here,
18 Stu, was DR 6.4 -- oh, it -- so it came from
19 the first case matrix. Right?

20 **MR. HINNEFELD:** Yeah, I'm sorry.

21 **MR. GRIFFON:** But it says revise IG-1 or other
22 document.

23 **MR. HINNEFELD:** I was writing my note. Which
24 number are we on?

25 **MR. GRIFFON:** Oh, 46.1, I'm sorry -- 46.1, and

1 it's DR 6.4, which would refer back to the
2 first set of twenty cases.

3 **MR. HINNEFELD:** Uh-huh.

4 **MR. GRIFFON:** But it -- revise IG-1 or other
5 document. I didn't know what that meant.

6 **MR. HINNEFELD:** Well, I didn't want to restrict
7 myself to IG-1. I think IG-1 will probably be
8 where it ends up, but there might be something
9 else where we'd want to put it in.

10 **MR. GRIFFON:** Okay.

11 **MS. BEHLING:** And this is --

12 **MR. HINNEFELD:** For example, this is about the
13 LOD over two issue.

14 **MR. GRIFFON:** Right.

15 **MS. BEHLING:** You got the memo?

16 **MR. HINNEFELD:** Yeah. We sent the -- we sent
17 the change management over, said hey, we want
18 you to do it this way. I mean, it involved
19 changes to a whole bunch of tools.

20 **MR. GRIFFON:** But you're going to incorporate
21 it in a procedure, but you're not sure, it
22 might be in others?

23 **MR. HINNEFELD:** I'm not sure of the best place
24 to put it. I think IG-1 is a good place to put
25 it, but there might be other places to put it

1 that would be better -- that would make more
2 sense. And so that's why I put that in there.
3 Might be Proc 6, might be somewhere else, you
4 know.

5 **MR. GRIFFON:** And as we follow it, we'll know.
6 Right? So --

7 **MR. HINNEFELD:** Yeah.

8 **MR. GRIFFON:** Okay. Forty -- the same thing on
9 the next two, yeah, so I'll just delete the
10 highlighting.

11 **MS. MUNN:** More of the same.

12 **MR. GRIFFON:** Sorry to be picky. I was just
13 looking for consistency. Forty-eight point
14 one's the same, question of the DCF-1, whether
15 it's bounding. Right?

16 **MR. HINNEFELD:** Yeah.

17 **MR. GRIFFON:** I'm down to 49.2. I guess I -- I
18 was just getting -- looking for clarification
19 on what the program evaluation report is.

20 **MS. BEHLING:** Mark? I'm sorry.

21 **MR. GRIFFON:** Oh, go ahead. Back?

22 **MS. BEHLING:** I -- I'm back. I'm back still
23 reading something. I'm way back on 47.1. And
24 --

25 **MR. GRIFFON:** Okay.

1 **MS. BEHLING:** I -- I assume that you thought
2 that this was the issue that we're still going
3 to discuss on the --

4 **MR. GRIFFON:** Yeah.

5 **MS. BEHLING:** -- the Hanford records.

6 **MR. GRIFFON:** But it's different?

7 **MS. BEHLING:** But I believe in this case, if I
8 recall, this -- we only received lifetime -- a
9 summary lifetime report and an annual exposure
10 records. We didn't have monthly or quarterly
11 records to verify. And I believe there was a
12 difference between those two --

13 **MR. GRIFFON:** Oh yeah.

14 **MS. BEHLING:** -- which we see, you know,
15 occasionally.

16 **MR. GRIFFON:** Yeah, I did -- I did characterize
17 that as a data collection --

18 **MR. HINNEFELD:** Yeah.

19 **MS. BEHLING:** Okay.

20 **MR. GRIFFON:** -- error. But you're right. The
21 action doesn't really reflect that, does it?

22 **MS. BEHLING:** No.

23 **MR. HINNEFELD:** I think -- well, they -- you're
24 right.

25 **MS. BEHLING:** And I believe what you typically

1 do is you look at the two and you select the
2 highest, and -- that's what I've seen, anyway,
3 in the past. I didn't know if there was any
4 other follow-up or if you try to get any of the
5 more detailed records.

6 **MR. HINNEFELD:** We did not follow up in this
7 case because the case could be completed.
8 Actually, it was a compensable case --

9 **MS. BEHLING:** Okay.

10 **MR. HINNEFELD:** -- using the lower numbers on
11 the reported exposure and not worrying about
12 missed and things like that. So we could --

13 **MR. MAHER:** Right. It was an underestimate and
14 it went comp right away.

15 **MR. HINNEFELD:** So since it was a compensable
16 case, we didn't really want to delay the
17 process by going back and asking for a record.

18 **MS. BEHLING:** Okay. But in -- in cases where
19 it's not a compensable case, 'cause I do see
20 this occasionally, do you just automatically
21 assume the highest? Do you try to go back and
22 get more detailed records?

23 **MR. MAHER:** We try to get the -- the -- the
24 regular monitoring data rather than the summary
25 data.

1 **MS. BEHLING:** Okay.

2 **MR. MAHER:** In fact we're doing that right now
3 with the bioassay at a number of the national
4 laboratories.

5 **MS. BEHLING:** Okay.

6 **MR. HINNEFELD:** So I think I'm going to change
7 the resolution, too. I mean I think the
8 resolution in this case was there was no nee--
9 you know, NIOSH felt there wasn't a need to --

10 **MR. MAHER:** On this case only.

11 **MR. GRIFFON:** On this case only, right. Right.

12 **MR. HINNEFELD:** Yeah. This sets a case-
13 specific decision on this case, we felt there
14 wasn't a need to.

15 **MS. BEHLING:** Okay -- that -- that I agree
16 with.

17 **MS. MUNN:** So, for the entire case we're doing
18 this?

19 **MR. GRIFFON:** Yeah, it's only one item.

20 **MR. HINNEFELD:** It's only one finding -- 47.1
21 is the only finding.

22 **MS. MUNN:** So it is -- since I was back on 46.

23 **MR. GRIFFON:** Okay. Sorry, I'm just taking
24 notes here. And I'm going to -- there's no
25 action on this one, is there? I think the

1 action for 36 stands alone, doesn't it? We
2 don't need to say for case 36 and 47.

3 **MR. HINNEFELD:** Right. The one for case 36
4 stands by itself.

5 **MR. GRIFFON:** Right, so no action on this. All
6 right. Are we back down to where I was there,
7 Kathy?

8 **MS. BEHLING:** Yes. I'm sorry.

9 **MR. GRIFFON:** Okay. That's all right, I'm glad
10 you caught it. So I was up to 49.2.

11 **MS. BEHLING:** Yes.

12 **MR. GRIFFON:** This que-- I think I know what
13 you mean here, Stu, but I just wanted to
14 clarify what the program evaluation report was.

15 **MR. HINNEFELD:** This is a non-Hodgkins
16 lymphoma. We've not that long ago changed the
17 target organ for that particular diagnosis to a
18 different target organ, so this case has to be
19 re-re-done anyway as part of that process to
20 determine whether the --

21 **MR. GRIFFON:** And then re-evaluated based on
22 the findings of the program evaluation report?

23 **MR. HINNEFELD:** Well --

24 **MR. GRIFFON:** I mean, not really via the
25 program --

1 **MR. HINNEFELD:** Well, we call --

2 **MR. GRIFFON:** -- or --

3 **MR. HINNEFELD:** A program evaluation report is
4 sort of the vehicle we use to evaluate
5 completed cases and the impac-- the impact on a
6 completed case when we make a change in
7 methodology --

8 **MR. GRIFFON:** Oh, okay.

9 **MR. HINNEFELD:** -- like this. So that's the
10 vehicle we use to evaluate that impact. And
11 it's --

12 **MS. BEHLING:** Okay.

13 **MR. HINNEFELD:** -- this is hundreds, I know, of
14 cases that are being re-evaluated. We're in
15 the middle of it.

16 **MS. BEHLING:** I was looking for an OCAS-PER.

17 **MR. HINNEFELD:** PER number?

18 **MS. BEHLING:** Yeah --

19 **MR. HINNEFELD:** I -- I don't know the PER num--
20 well, the actual PER is probably going to be
21 wrapped up when we've decided which ones to get
22 back from Labor and rework and things like
23 that, so --

24 **MS. BEHLING:** That explains that.

25 **MR. GRIFFON:** So I think we're okay on that.

1 It was just a matter of a clarification of what
2 that document was. Fifty point three?

3 **MR. HINNEFELD:** Oh, yeah. This is a -- has to
4 do with how -- which DCF was applied to the
5 ambient dose in -- at Fernald.

6 **MS. BEHLING:** Oh.

7 **MR. HINNEFELD:** I think we'd like -- if we're
8 going to address this, let's roll it into the
9 Fernald TBD question because it has several
10 years worth of data where it's -- the data's
11 reported in a particular table as mrem per
12 hour, and did they really adjust? Because the
13 early environmental measurements were made with
14 film, which probably wouldn't be an mrem, it
15 would be an mR measurement, which would require
16 a different DCF and at some point
17 (unintelligible) change -- and we're talking
18 about a couple of hundred millirem a year in
19 most cases. In some cases it'd be higher than
20 that. If -- I mean, if we want to pursue a
21 resolution here, I think we should just kind of
22 -- the Fernald site profile's being reviewed
23 and we can try to just make sure it's clear
24 that that site profile clearly specifies what
25 to do with these numbers, whether it's mrem or

1 mR.

2 **MS. BEHLING:** I believe I recall that this was
3 just an issue of consistency we made and I
4 noticed --

5 **DR. BEHLING:** Yeah, I mean if you go back -- if
6 you back to the original report, I -- I
7 highlighted -- I said, for mere consistency --

8 **MR. GRIFFON:** Yeah, yeah.

9 **DR. BEHLING:** -- (unintelligible) you have to
10 (unintelligible) recorded missed dose. Where
11 they used the DCF of 1.244 --

12 **MR. HINNEFELD:** Yeah.

13 **DR. BEHLING:** -- they should have applied that
14 same --

15 **MS. BEHLING:** Applied it also.

16 **DR. BEHLING:** -- elevated -- we know it's a
17 generous --

18 **MR. HINNEFELD:** Yeah.

19 **DR. BEHLING:** -- gift to -- to be given that
20 value, but it was strictly one of consistency.
21 If you're going to apply it there, why wouldn't
22 you apply it for ambient dose.

23 **MR. HINNEFELD:** Right. Right. Well th-- and
24 again, if the ambient dose -- it was
25 undoubtedly early on measurable film if they

1 **MR. GRIFFON:** Which one are you at, Kathy?

2 **MS. BEHLING:** Oh, I'm sorry, 51.1.

3 **MR. GRIFFON:** Yeah.

4 **MS. BEHLING:** Are you -- is Ray okay?

5 **MR. GRIFFON:** Yep, he's fine.

6 **THE COURT REPORTER:** Yeah.

7 **MR. GRIFFON:** He's not dozing off again.

8 **MS. BEHLING:** No.

9 **MR. GRIFFON:** That was only this morning.

10 **MS. BEHLING:** I believe this is the situation
11 where the Fernald -- the occupational medical
12 dose that was identified in the TBD is
13 inconsistent with -- was it with another TBD or
14 was it with OTIB-6?

15 **DR. BEHLING:** I think they just broke rank with
16 the rest of the DOE complex values.

17 **MR. MAHER:** No, there is a -- there is a
18 difference in the dose here between those
19 documents she referenced, and we have since
20 verified that as being fixed.

21 **MS. BEHLING:** Okay.

22 **MR. MAHER:** In -- in this case it's a .3 rem
23 difference so the -- would not affect the
24 compensability outcome.

25 **MR. GRIFFON:** Right.

1 **MS. BEHLING:** Okay. Just so that this is
2 followed through and -- and (unintelligible).

3 **MR. MAHER:** But the X-rays cited Fernald at the
4 table there. Yeah.

5 **MS. BEHLING:** Okay.

6 **MR. GRIFFON:** Does the -- does the action
7 stand?

8 **MR. HINNEFELD:** That's the action we're in the
9 middle of.

10 **MR. GRIFFON:** Right. You're in the middle of
11 it.

12 **MR. MAHER:** That's right, we're right in the
13 middle of that right now.

14 **MR. GRIFFON:** Okay. Kathy, I'm waiting for
15 you. I'm down at 54.

16 **MS. BEHLING:** Okay, I -- I'm moving, yeah.

17 **MR. GRIFFON:** Hurry up, hurry up -- no.

18 **MS. BEHLING:** These are all TIB-10s again. I'm
19 down to 55 -- (unintelligible) 55. Okay.

20 **MR. GRIFFON:** Yeah. A lot of TIB-10s, TIB-8s,
21 yep.

22 **MS. BEHLING:** TIB-8s and 10s, okay. Now we're
23 down to --

24 **MR. GRIFFON:** Fifty-six point four?

25 **MS. BEHLING:** -- 56.4.

1 **MR. GRIFFON:** 56.4, everyone.

2 **MS. BEHLING:** Yeah, the wording in this section
3 of the NIOSH resolution is not really great
4 wording, but --

5 **MR. GRIFFON:** Yeah, right. Well, I might have
6 written that, too. That might explain it. It
7 was actually not when I was sleepy. But I
8 looked back -- I looked back at it and
9 highlighted it and said what did I write?

10 **MR. HINNEFELD:** I don't think I've ever
11 presumed to write not -- "SC&A agrees". I
12 don't believe I've ever written that.

13 **MS. MUNN:** It's -- it's too presumptuous.

14 **MR. HINNEFELD:** Yeah.

15 **MS. BEHLING:** Okay. I did go back and look at
16 this case and I -- this was an issue where the
17 worker was a steam plant operator and did work
18 in areas where there were potentially neutron
19 exposures, and the records -- I guess I'm going
20 to go back to rehash this, but the records did
21 show zero under neutron as if she was
22 monitored, and it was zero, and I just thought
23 in that case --

24 **MR. GRIFFON:** Right.

25 **MS. BEHLING:** -- there was -- they could have

1 assigned missed neutron dose. And I guess you
2 felt that, based on -- on the job title and the
3 work locations, she would not have been
4 necessarily exp--

5 **MR. HINNEFELD:** Yeah the -- the approach that's
6 taken -- certain -- certain sites hang -- when
7 they hang a dosimeter, there's a neutron
8 component. And so there's always a neutron
9 component in the -- in the badge, regardless of
10 whether a person has potential for exposure.

11 **MR. GRIFFON:** That was the explanation.

12 **MS. BEHLING:** Okay.

13 **MR. HINNEFELD:** And so the record will show
14 that zero in the neutron column, and so for
15 those sites, we try to judge -- by job title
16 and assignment -- whether there's potential for
17 neutron exposure or not. I'm not intimately
18 familiar with this case, so I don't --

19 **MR. GRIFFON:** My recollection was at last
20 meeting you had kind of accepted this
21 explanation, yeah -- yeah.

22 **MS. BEHLING:** I -- yeah, I -- and we -- I did
23 go back and I -- I calculated what that neutron
24 dose would have been and if it would have
25 impacted this case, and it would not have.

1 **MR. GRIFFON:** It would not have anyway, right,
2 so, yeah.

3 **DR. BEHLING:** Yeah -- 720 milligrams --

4 **MR. GRIFFON:** Right.

5 **MS. BEHLING:** I still thought that initially I
6 was legi--

7 **MR. HINNEFELD:** Yeah.

8 **MS. BEHLING:** -- it was a legitimate issue,
9 that neutron dose.

10 **MR. GRIFFON:** So I've slightly reworded that
11 resolution. SC&A agrees based on job title
12 information --

13 **MR. MAHER:** Well -- a lot of this is the
14 professional judgment of the DR after reading,
15 you know, the information about the EE and the
16 CATIs and all that and, you know, there are
17 differences of opinions among people whether
18 they should be or not.

19 **MS. BEHLING:** Sure.

20 **MR. GRIFFON:** Right, right.

21 **MR. MAHER:** But there are consistent, you know,
22 pretty constant problems throughout this
23 project, yeah. Not a problem, but a difference
24 of opinion.

25 **MS. BEHLING:** Right.

1 The only --

2 **MS. BEHLING:** Okay --

3 **MR. GRIFFON:** -- thing I wanted to approve --
4 go ahead, if we need to go back?

5 **DR. BEHLING:** Fifty-six point five -- is that
6 one still under re-- under review? We'll be
7 able to determine --

8 **MR. GRIFFON:** Oh, yeah.

9 **MR. HINNEFELD:** Yeah, we're going to try to --
10 we'll make another attempt and see if we can
11 find bias in that.

12 **MS. BEHLING:** Okay.

13 **MR. HINNEFELD:** Yeah.

14 **MS. BEHLING:** Okay.

15 **MR. GRIFFON:** Then we got the TIB-10s.

16 **MS. BEHLING:** TIB-10s, okay, I'm good.

17 **MR. GRIFFON:** Then we're up to 57.4 is -- the
18 only question I had was the note that, Stu, you
19 had added this, I think.

20 **MR. HINNEFELD:** Well, the finding was that --
21 should you -- I think the finding was that --
22 should -- shouldn't have used the 12 -- should
23 have used the 12 radionuclide --

24 **MS. BEHLING:** You're right.

25 **MR. HINNEFELD:** -- intake. And we felt like

1 well, there was places --

2 **MS. BEHLING:** Yes.

3 **MR. HINNEFELD:** -- where fission products are a
4 problem, so we felt like using the 28 nuclide
5 was appropriate.

6 **MR. GRIFFON:** So we --

7 **MR. HINNEFELD:** But I just threw it in --

8 **MS. BEHLING:** That is. That's appropriate.

9 **MR. GRIFFON:** -- so we accept that?

10 **MS. BEHLING:** Yeah.

11 **MR. GRIFFON:** All right. Un-highlight it.

12 **MS. MUNN:** (Unintelligible)

13 **MR. HINNEFELD:** Hey, fission products are
14 fission products.

15 **MS. MUNN:** Yeah, I know. I know, I know.

16 **MR. GRIFFON:** Just -- just to stay on that one
17 for a second, is this -- SC&A agrees with this
18 then, so -- and -- and...

19 **MS. BEHLING:** Yes.

20 **MR. GRIFFON:** Well, wait a second, there -- are
21 this -- this is two parts again.

22 **MR. HINNEFELD:** It's two parts. One is the
23 selection of the organ --

24 **MR. GRIFFON:** It's the organ and the --

25 **MR. HINNEFELD:** -- and it was --

1 **MR. GRIFFON:** -- 28 radi-- yeah, so there's --

2 **MR. HINNEFELD:** -- it was an early model that
3 only allowed use of the --

4 **MR. GRIFFON:** So -- okay.

5 **MR. HINNEFELD:** -- of the colon, and now --

6 **MR. GRIFFON:** There's two parts.

7 **MR. HINNEFELD:** -- the model allows a broader
8 selection.

9 **MR. GRIFFON:** So you agree with the one part
10 but the other point is --

11 **MR. HINNEFELD:** Yeah.

12 **MR. GRIFFON:** - right, okay. Gotcha. All
13 right. Fifty-eight point three. This is gone,
14 this highlighted section -- again, the CATI.

15 **MS. MUNN:** Yeah, we eliminate that whole
16 (unintelligible). Right?

17 **MR. GRIFFON:** Yeah. And I'm down to 60.

18 **MS. BEHLING:** Okay, 59 is being re-evaluated.

19 **MR. HINNEFELD:** Yeah.

20 **MS. BEHLING:** Case 59.

21 **MR. HINNEFELD:** Yeah.

22 **MR. GRIFFON:** And actually so is 60,
23 apparently.

24 **MS. BEHLING:** Same with 60.

25 **MR. GRIFFON:** On 68.2, Stu, the thing I had

1 here was 60.1 and 60.3 said "attempt to resolve
2 differences and re-evaluate the" -- it seemed
3 like -- and then -- it seemed like the whole
4 case was being re-evaluated and you had
5 something different for 60.2, I forget what you
6 had. I should have saved changes. Or -- or --
7 tracked changes.

8 **MR. HINNEFELD:** I don't remember 60 right off
9 hand.

10 **MR. GRIFFON:** Shoot, I don't know if I have --
11 I do, hold on one second. I've got the old
12 hard copy.

13 **MR. HINNEFELD:** Oh, I remember now.

14 **MR. GRIFFON:** You got it?

15 **MR. HINNEFELD:** This person worked at Pantex
16 for two years and was -- I believe this is one
17 who was a patrol officer -- so we felt like if
18 -- if this is -- you know, if 60.2 is
19 correctly, you know, summarized there, we feel
20 like the hypothetical intake -- you know, a
21 TIB-2 intake -- was certainly being
22 conservative for -- for that person in a two-
23 year work history.

24 **MR. GRIFFON:** I guess what I was questioning is
25 in the resolution column we had "NIOSH will re-

1 do case" for all three of those, and then I saw
2 no action for 60.2. It looked a little
3 strange, you know.

4 **MR. HINNEFELD:** Well, the re-working of the
5 case -- or the -- actually what we said we'd do
6 is we would try -- there's a difference between
7 the exposure record we got and the guy's
8 employ-- verified employment records.

9 **MR. GRIFFON:** So you don't have to re--

10 **MR. HINNEFELD:** He has verified employment for
11 two years in the '80's. There's like one -- I
12 think there's a triti-- one tritium bioassay
13 sample from the '90's.

14 **MR. GRIFFON:** So then we need to--

15 **MR. HINNEFELD:** -- and that's the extent of his
16 monitoring records.

17 **MR. GRIFFON:** We need to change the resolution
18 column, not the action column.

19 **MR. HINNEFELD:** I believe the action column
20 speaks to what we intended to do. We're going
21 to try to see if we can't resolve why does the
22 guy have verified two years of employment --
23 verified employment in the '80s and one tritium
24 sample in the '90's.

25 **MS. BEHLING:** Yes.

1 **MR. HINNEFELD:** You know, why did that happen?
2 And -- and then -- but as far as the TIB-2
3 intake, it's hard to imagine that a patrol
4 officer in two years at Pantex would have more
5 than a TIB-2 intake, because --

6 **MS. BEHLING:** Agreed.

7 **MR. HINNEFELD:** -- a TIB-2 intake is like 110
8 DAC years of intake.

9 **MR. GRIFFON:** Right, right.

10 **MS. BEHLING:** Right.

11 **MR. GRIFFON:** So SC&A agrees -- the resolution
12 is SC&A agrees with this -- NIOSH's response on
13 the 28 radionuclide question. Right?

14 **MS. BEHLING:** But -- but you still are going to
15 go back and see if you --

16 **MR. HINNEFELD:** We're going to try to resolve
17 that difference --

18 **MS. BEHLING:** -- to resolve that --

19 **MR. HINNEFELD:** -- in the records, yeah.

20 **MS. BEHLING:** Yeah --

21 **MR. HINNEFELD:** We're going to try to do that.

22 **MS. BEHLING:** -- just because those records
23 were very strange --

24 **MR. GRIFFON:** But that's for 60.1 and 3.

25 **MR. HINNEFELD:** Yeah.

1 **MS. BEHLING:** Yes.

2 **MR. GRIFFON:** Yeah. So you don't really have
3 to do anything with the 28 ra-- that part of
4 it.

5 **MR. HINNEFELD:** Right.

6 **MR. GRIFFON:** So I'm going to change 60.2 --
7 the resolution to read "SC&A agrees with NIOSH
8 response" and then no action. That's for 60.2.

9 **MR. MAHER:** This where -- the case the claimant
10 claims to have had something in 1990?

11 **MR. HINNEFELD:** No, we've got -- it's on his
12 exposure record, Ed. He's got like one tritium
13 bioassay sample from '92 or '94 or something
14 like that, and his verified employment is two
15 years in the '80's.

16 **MR. GRIFFON:** Right.

17 **MS. MUNN:** And it may be a clerical error.

18 **MR. GRIFFON:** Cler-- yeah, yeah.

19 **MR. HINNEFELD:** So he may have gone back as a
20 -- on a tour.

21 **MS. MUNN:** Could have been that.

22 **MR. MAHER:** That's right.

23 **MS. MUNN:** Or it could be a clerical error.

24 **MS. BEHLING:** But the other thing that was
25 strange is the only records I -- as I recall,

1 were summary records, and those summary records
2 were dated like 1992. And it was so much
3 discrepancy between the dates on these various
4 records, and there wasn't -- there was no
5 detailed records. It was always summary or
6 annual records.

7 **MR. HINNEFELD:** I was thinking we just had one.
8 I -- I thought we only had one record. It was
9 like --

10 **MR. MAHER:** Right, just one record.

11 **MR. HINNEFELD:** -- one -- one indication, or
12 maybe it was one year's -- maybe it was annual
13 tritium dose of zero or something in '92 or
14 something like that. But I was thinking it was
15 really (unintelligible).

16 **DR. BEHLING:** There may also have been a
17 discrepancy between issues of statements made
18 in the CATI report regarding --

19 **MR. MAHER:** That's what I think it was is --

20 **DR. BEHLING:** -- monitoring.

21 **MR. MAHER:** -- CATI --

22 **MR. HINNEFELD:** Yeah, we'll --

23 **MR. MAHER:** -- where he had (unintelligible) --

24 **MR. GRIFFON:** So you're going to check those
25 either way.

1 **MR. HINNEFELD:** Yeah.

2 **MS. BEHLING:** But you're going to check into
3 it.

4 **MR. HINNEFELD:** We're going to chase it down.

5 **MS. BEHLING:** Plus the work history, it was a
6 combination.

7 **MR. MAHER:** Yeah and -- and where we often see
8 the claimants confused security badges with
9 dosimeter badges.

10 **MR. HINNEFELD:** Yeah, and just people
11 oftentimes in a CATI say that they have -- were
12 breath -- had breath monitoring. Breath
13 monitoring as bioassay was really only done for
14 radium.

15 **MS. MUNN:** Yeah.

16 **MR. HINNEFELD:** And -- and -- they -

17 **MR. MAHER:** He was given 22 rem --

18 **MR. HINNEFELD:** Yeah.

19 **MR. MAHER:** -- and with POC of 18 percent.

20 **MR. GRIFFON:** Right.

21 **DR. BEHLING:** I mean --

22 **MR. HINNEFELD:** We'll take another look. We'll
23 try to resolve the record for the
24 (unintelligible).

25 **MR. GRIFFON:** Just those discrepancies, right.

1 **MR. HINNEFELD:** But I don't think the case is
2 going to change.

3 **MR. GRIFFON:** But the -- the middle -- the 60.2
4 remains. No action on 60.2.

5 **MS. MUNN:** Doesn't make any sense, 22 rem
6 (unintelligible) -

7 **FOURTH SET MATRIX**

8 **MR. GRIFFON:** And then we're -- we're up to the
9 fourth matrix. Only an introduction.

10 **MR. HINNEFELD:** I'm not ready to talk about it.

11 **MR. GRIFFON:** I know, I know. I did want to --

12 **MR. HINNEFELD:** Except in general terms.

13 **MR. GRIFFON:** I think we're done with the third
14 -- are we done with the third set?

15 **MS. BEHLING:** Yes.

16 **MR. GRIFFON:** The only way I -- the only thing
17 I did want to do is just maybe get a path
18 forward on the fourth set. Kathy and Hans, can
19 I ask -- I have a version here -- I think in
20 the title here it -- it doesn't have a date on
21 the matrix.

22 **MS. BEHLING:** That was probably the initial
23 matrix that I generated, that I sent in. Is
24 there a date in the bottom?

25 **MR. GRIFFON:** There's no date.

1 **MS. BEHLING:** No date?

2 **MR. GRIFFON:** No dates at all.

3 **MS. BEHLING:** Okay.

4 **MR. GRIFFON:** Maybe you can e-- e-mail -- have
5 you done any -- not -- any --

6 **MR. HINNEFELD:** I've not added any responses.

7 **MR. GRIFFON:** -- responses? No NIOSH responses
8 at this point.

9 **MS. BEHLING:** But you have my matrix.

10 **MR. HINNEFELD:** Yes.

11 **MS. BEHLING:** Okay.

12 **MR. HINNEFELD:** Yes.

13 **MS. BEHLING:** He has my matrix.

14 **MR. HINNEFELD:** I have the matrix. I've not
15 put anything in the matrix and so I've not made
16 any modifications to it. We have done some
17 work on the cases and so we have some
18 information we could put in there.

19 **MR. GRIFFON:** Right.

20 **MR. HINNEFELD:** But I have not gone to the step
21 of getting it in there.

22 **MR. GRIFFON:** This is the fourth set. I don't
23 know --

24 **MR. HINNEFELD:** Fourth set.

25 **MS. BEHLING:** Fourth set.

1 **MR. GRIFFON:** -- if you have it. We might --
2 if you could, maybe e-mail it again, just to
3 the work group?

4 **MS. BEHLING:** Okay.

5 **MR. GRIFFON:** And I think you should e-mail it
6 to John Poston, too, because I think when we
7 pick this up again we'll be in our subcommittee
8 -- right, Lew? Yeah.

9 **MS. BEHLING:** Is there any general comments
10 that you want to make about the fourth set of
11 cases?

12 **MR. HINNEFELD:** Well, I'll say this. There --
13 there are a number of -- there are a few cases
14 -- I think there are three cases in there where
15 it was identified that overestimating
16 approaches were used on a compensable claim.

17 **DR. MAURO:** OTIB-4.

18 **MR. HINNEFELD:** And so -- yeah, TIB-4, a TIB-4
19 approach. And so I can say a little bit about
20 how that came to pass.

21 **MS. BEHLING:** Okay, bec--

22 **MR. HINNEFELD:** This was a -- an effort on our
23 part to identify cases where we may not ever do
24 any better than a general approach. And we
25 have a generous approach and I thought it would

1 be to our benefit in order to -- well, not
2 necessarily I -- we thought it would be in our
3 benefit, if we are in a situation where we have
4 some sites where we may never ever do any
5 better than this --

6 **MS. BEHLING:** So you don't --

7 **MR. HINNEFELD:** -- we may not refine it any
8 better.

9 **MS. BEHLING:** Okay.

10 **MR. HINNEFELD:** This might be the best we can
11 do. Now, in doing that, in our haste to get
12 these cases out, we neglected some things. For
13 instance, we didn't modify TIB-4 to say things
14 like this is an overestimating case or can be
15 used in cases where the -- the exposures cannot
16 be refined any further. And so TIB-4 really
17 precludes its use in a compensable case and so
18 that was our bad. But we did it with the best
19 of intentions. We did it with the best of
20 intentions in order to make progress on cases
21 where we didn't foresee making any better
22 estimate, any more refined estimate, and doing
23 an estimate in those cases.

24 **MR. GRIFFON:** And wh-- where are these. I
25 think we can say without identifiers where

1 these cases were from. Do you recall?

2 **MR. HINNEFELD:** If I recall -- and whether they
3 were --

4 **MR. GRIFFON:** Were they all AW-- small AWE
5 sites?

6 **MR. HINNEFELD:** They gen-- they tended to be
7 AWEs but they weren't, and so there's another
8 question of did we -- did we apply our approach
9 appropriately or did we make mistakes in the
10 application, and that's probably on the
11 (unintelligible).

12 (Whereupon, multiple participants spoke
13 simultaneously.)

14 **DR. BEHLING:** AWE facilities where we
15 questioned not just the -- the use of it for
16 compensation, but the fact that they may not be
17 appropriate.

18 **MR. HINNEFELD:** Right.

19 **MR. GRIFFON:** Right.

20 **MR. HINNEFELD:** So the application of what we
21 were attempting to do we didn't pull off very
22 well.

23 **DR. MAURO:** There were two problems that I
24 thought of as part of this process. One had to
25 do with -- in fact one was Bridgeport Brass

1 where you used OTIB-4 as a -- where a -- I
2 think there -- and Hans and Kathy, please help
3 me out. When I -- when I reviewed the
4 Bridgeport Brass, this first one, where you
5 used OTIB-4 and you compensated. Now there is
6 a Bridgeport Brass site profile. Now my
7 concern goes toward okay, now that the site
8 profile is out, and a dose reconstructor has
9 access to that, and then let's say deny using
10 the site profile, you're -- you're in a
11 difficult situation, and you underst-- so --

12 **MR. HINNEFELD:** Oh, sure.

13 **DR. MAURO:** -- and we're -- we're about to do
14 that again 'cause I think I -- we have some new
15 cases now --

16 **MR. HINNEFELD:** Yeah, I believe there are
17 probably five.

18 **DR. MAURO:** -- where we -- and I'm not quite
19 sure what would happen there, whether he's a
20 compensating or not, but you could see -- I
21 could see the problem coming up -- oh, we used
22 the site profile and denied on a -- on one
23 case, but in another case, you used TIB-4 and
24 granted. So I -- that -- that was one dilemma.
25 And of course the other was using TIB-4 for a

1 site that was not an AWE, such as West Valley.

2 **DR. BEHLING:** No, it's an AWE but not --

3 **DR. MAURO:** West Valley was AWE?

4 **MR. HINNEFELD:** It's not -- it's not a uranium
5 handling --

6 **DR. MAURO:** Not a uranium handling. Okay.

7 **DR. BEHLING:** Because it's not a uranium
8 facility, so...

9 **DR. MAURO:** Okay.

10 **MS. BEHLING:** And --

11 **MR. HINNEFELD:** The -- go ahead.

12 **MS. BEHLING:** Excuse me, 'cause -- and then
13 there's a third issue as to whether we should
14 assume now that TIB-4 can be used to compensate
15 cases for AWEs where you do not intend to
16 develop a site profile.

17 **MR. HINNEFELD:** Well, not in its present form.
18 Not as -- not in the words on the page today.
19 There would have to be changes to the words on
20 the page on TIB-4 to allow that use.

21 **MS. BEHLING:** Okay. Okay.

22 **MR. HINNEFELD:** This entire population of
23 claims came -- was done in a short period of
24 time in 2005 that -- we know the entire
25 population of claims. We're in discussion with

1 DOL about what will happen with these claims,
2 so it's -- it's an issue that clearly is on the
3 table that we're having --

4 **MR. GRIFFON:** I mean Stu, is this -- I'm trying
5 to understand -- was this kind of an ad hoc
6 policy in -- in application of TIB-4 or --

7 **MR. HINNEFELD:** Yeah, I guess you would call it
8 that.

9 **MR. GRIFFON:** How did you decide what
10 facilities -- it was kind of within your --
11 within your DR group? Or how -- I don't
12 understand the sort of process on how this was
13 -- determinations were made.

14 **MR. HINNEFELD:** Well, there's intent and then
15 there's execution and --

16 **MR. GRIFFON:** Yeah.

17 **MR. HINNEFELD:** -- communication failures and
18 communication breakdowns.

19 **MR. GRIFFON:** I mean I'm not trying to point at
20 -- I'm just trying to understand --

21 **MR. HINNEFELD:** The intent was that there is
22 this population of claims that OTIB-4 -- there
23 were the uranium sites that TIB-4 correctly
24 applies to. Chances are we will not be able in
25 any kind of timely fashion to do any better

1 than this, so we -- we should use this as -- we
2 can't refine the estimate any more than this.
3 It -- that was the intent. That was the
4 thought process.

5 **DR. WADE:** And the -- the policy level was made
6 at the Director of NIOSH's level.

7 **MR. HINNEFELD:** Yes. The execution and
8 communication of that, among our own staff and
9 to our contractor -- there were some
10 communication failures in terms of how the
11 implementation of that should go. And so,
12 based on that, some things -- some -- it was
13 applied more broadly than chances are it would
14 have been applied. This was an attempt to move
15 cases. You know, this was May of 2005. There
16 was a lot of pressure to move cases. We were
17 doing it for the best of purpo-- best of
18 reasons --

19 **MR. GRIFFON:** Right.

20 **MR. HINNEFELD:** -- to try to get answers to
21 people, and -- and in looking for broader
22 application, we just pushed the boundaries of
23 applicability beyond the point it should have
24 been.

25 **DR. BEHLING:** Has -- has TIB-4 been revised

1 currently to the point where it can be used for
2 compensating claims and -- and -- in a sense --

3 **MR. GRIFFON:** I think he said no.

4 **MS. BEHLING:** He said no.

5 **DR. BEHLING:** -- that it defines bounding
6 values -- it has not?

7 **MR. HINNEFELD:** No. No, it has not. And it's
8 not being used in that -- has not been used in
9 that sense for probably over a year.

10 **DR. BEHLING:** But we will tell you that --

11 **MS. BEHLING:** This set.

12 **DR. BEHLING:** -- in the sixth set has a number
13 of --

14 **MR. HINNEFELD:** They were all done in that same
15 period.

16 **DR. BEHLING:** Okay.

17 **MR. GRIFFON:** They were all done in the same
18 time frame, yeah.

19 **DR. BEHLING:** So in all likelihood we will then
20 be forced to just bring that up as an issue.

21 **MR. HINNEFELD:** You'll have -- it'll be the
22 same issue. It'll be just like -- it'll be
23 TIB-- TIB-8 and TIB-10 revisited. It'll be --

24 **MR. MAHER:** For -- for more than a year now our
25 direction is not to use overestimates on co--

1 compensable cases.

2 **DR. BEHLING:** I was under the impression that
3 perhaps there had been some revisions where you
4 would say TIB-4 provides bounding estimates,
5 and since we're not going to use -- develop
6 TBDs, then it can be used to reach a --

7 **MR. HINNEFELD:** We may in fact get there. We
8 may do that.

9 **DR. WADE:** It's a reasonable approach.

10 **MR. HINNEFELD:** It is a reasonable approach to
11 do.

12 **DR. BEHLING:** If that's a statement in the TIB,
13 then that's fine.

14 **MR. HINNEFELD:** Exactly.

15 **DR. WADE:** But as Stu said, it hasn't been
16 modified.

17 **MR. HINNEFELD:** Yeah, it has not been modified
18 to that effect yet.

19 **MR. GRIFFON:** At this -- at this point, Stu,
20 you have -- is there one of these -- I forget
21 what they're called, directives or whatever,
22 that you -- things like you said were --

23 **MR. HINNEFELD:** I could probably come up with a
24 --

25 **MR. GRIFFON:** -- in touch with that e-mail

1 stream --

2 **MR. HINNEFELD:** I can probably come up with a
3 trail.

4 **MR. GRIFFON:** -- that show that a year ago you
5 -- you --

6 **MR. HINNEFELD:** I told them to do this and then
7 --

8 **MR. GRIFFON:** Right.

9 **MR. HINNEFELD:** -- later on told them to stop?
10 I think I probably can.

11 **MR. GRIFFON:** I mean as we go down the matrix,
12 I think that might be useful, you know.

13 **MR. HINNEFELD:** I think I probably can.

14 **DR. MAURO:** What might help the process also is
15 we just completed a review of Rev 3 of TIB-4,
16 the latest version of TIB-4.

17 **MR. HINNEFELD:** Okay.

18 **DR. MAURO:** And -- and by and large, the most
19 important aspect of it has to do with adopting
20 the 100 MAC as the default upper bound value
21 and we -- we come away with saying that that is
22 a reasonable, plausible upper bound. That is,
23 when you look at the distribution of the data
24 upon which that 100 MAC was selected, it falls
25 in at about the upper 95th percentile of the

1 distribution measurements that were made for
2 those seven facilities that were used --

3 **MR. HINNEFELD:** Right.

4 **DR. MAURO:** -- as the basis for it.

5 **MR. HINNEFELD:** Right.

6 **DR. MAURO:** So what I'm getting at is I could
7 see TIB-4 being a very functional upper --
8 plausible upper bound for AWE --

9 **MS. BEHLING:** Appropriate AWEs --

10 **DR. MAURO:** Appropriate, yeah. It's
11 appropriate and not some -- some gross
12 unrealistic, unreal overestimate or whatever.

13 **MR. HINNEFELD:** Right.

14 **MR. GRIFFON:** Yeah.

15 **MR. HINNEFELD:** And we -- we may do that.

16 **MS. BEHLING:** But you're not there yet.

17 **MR. HINNEFELD:** But we are not doing it today.

18 **MS. BEHLING:** Okay. That helps us with moving
19 on.

20 **MR. HINNEFELD:** Yeah.

21 **MS. BRACKETT:** And isn't Battelle doing the
22 AWEs now anyway? Would they be using
23 (unintelligible)?

24 **MR. HINNEFELD:** I -- I'm not really up to date
25 on what they're doing. But Battelle -- many of

1 these sites are now the responsibility for
2 Battelle to do the dose reconstructions and so
3 --

4 **DR. WADE:** It's a policy decision.

5 **MR. HINNEFELD:** But a policy decision's a
6 policy decision.

7 **DR. BEHLING:** Okay. That answers a lot of
8 critical questions for the next set.

9 **MS. BEHLING:** Yes. Yes.

10 **MR. GRIFFON:** I think that's -- I mean I don't
11 know that we can go much further with this
12 fourth set. Really I -- I, you know, it -- I
13 think at the next Board meeting we should be in
14 a position where we're going to set up our
15 subcommittee. Right? And we'll carry this
16 work over into the subcommittee, I assume.

17 **DR. WADE:** We were going to try to charter it
18 on a call --

19 **MR. GRIFFON:** Right.

20 **DR. WADE:** -- and have it ready to go in
21 September.

22 **MR. GRIFFON:** Yeah. Okay. So if -- if --
23 maybe by the September meeting, Stu, do you
24 think it's realistic that you might have
25 responses at least for part of this matrix?

1 **MR. HINNEFELD:** Yeah.

2 **MR. GRIFFON:** Okay.

3 **MR. HINNEFELD:** By the September Board meeting,
4 we said the 19th of September?

5 **MR. GRIFFON:** Yeah.

6 **MR. HINNEFELD:** We can cer-- I mean, we have
7 some pieces and parts --

8 **MR. GRIFFON:** Right.

9 **MR. HINNEFELD:** -- I just haven't put it on the
10 matrix yet, and so we do have some -- I can
11 have some (unintelligible).

12 **MR. GRIFFON:** I mean if -- if -- even if it's
13 still, you know, under -- under further review
14 or whatever, you know --

15 **MR. HINNEFELD:** Yeah.

16 **MR. GRIFFON:** -- but if you can get a lot -- if
17 you can get most of them and there's a few
18 outstanding --

19 **MR. MAHER:** Stu, we -- we have completed our
20 responses to that fourth set.

21 **MR. HINNEFELD:** Okay. So they're --

22 **MR. GRIFFON:** Yeah, okay.

23 **MS. MUNN:** Just about ready.

24 **MR. GRIFFON:** So we -- we'll pick that up in
25 September and carry it into the subcommittee, I

1 think.

2 **DR. WADE:** And now you do have the fifth and
3 sixth sets.

4 **MR. GRIFFON:** Fifth and sixth set? Yeah, and
5 on those I think I had asked SC&A to look at
6 that listing and look at the cases and see if
7 the cases lined up with the definition of best
8 estimate or maximum-minimum case. And Kath--
9 Kathy e-mailed a response and I don't know that
10 I'm -- I haven't cross-walked -- the one
11 question I had was there was a -- I haven't
12 cross-walked it with what we thought the fir--
13 when we had the selection matrices we had a
14 final column. And Stu you said that, you know,
15 this was a judgment so it might -- there might
16 be some areas or some, you know --

17 **MR. HINNEFELD:** Yeah.

18 **MR. GRIFFON:** -- but I haven't cross-walked --
19 have you cross-walked that, Kathy, or --

20 **MS. BEHLING:** No --

21 **MR. GRIFFON:** All right.

22 **MS. BEHLING:** No, I haven't I --

23 **MR. GRIFFON:** What I wanted to look at was did
24 the selections match up with the reality on
25 those cases. In other words, if we thought we

1 had ten best estimates and ten --

2 **MS. BEHLING:** Yes.

3 **MR. GRIFFON:** -- max, did we get ten, then ten?

4 And --

5 **MS. BEHLING:** In the fifth set -- especially
6 the fifth set -- I do not believe that you did
7 because we also went into the fifth set -- you
8 all went into the fifth set in selecting cases
9 of AWEs that we haven't reviewed yet. Some of
10 those -- most of those AWEs were on that list
11 of full external/full internal. But I think,
12 as you would define a best estimate, they -- in
13 my mind -- would not be considered a best
14 estimate. However, they were on that list of
15 full internal/full external.

16 **MR. HINNEFELD:** An AWE that was done in
17 accordance with a one-size-fits-all TIB --

18 **MR. GRIFFON:** Right.

19 **MS. BEHLING:** Right.

20 **MR. HINNEFELD:** -- would be -- we would click
21 as best estimate.

22 **DR. MAURO:** We would click it as best estimate.

23 **MS. BEHLING:** Exactly.

24 **DR. MAURO:** At the Linde site, that was a best
25 estimate.

1 **MR. GRIFFON:** And I think I'll -- I'll try to
2 present something at that on the August 8th
3 phone call and -- and -- because the -- it
4 still may be important, especially for those
5 AWEs that don't have TIBs. Even though it's a
6 one-size-fits-all, this may be our shot at
7 reviewing that site, more or less, you know.
8 So it may still be that the Board wants to do
9 that, you know. And I think it will be.

10 **MS. BEHLING:** And it's --

11 **MS. MUNN:** It might not be a bad idea.

12 **MS. BEHLING:** It was difficult --

13 **MR. GRIFFON:** Right. Right.

14 **MS. BEHLING:** It was difficult for me to
15 classify those, and so I tried to put a little
16 bit of a different explanation. Rather than
17 putting min/max or best estimate, I said
18 compensated using TIB-4 or some -- something
19 along those lines. But I know what your idea
20 of a best estimate is --

21 **MR. GRIFFON:** Yeah.

22 **MS. BEHLING:** -- and I wouldn't think that
23 those fall into that category.

24 **MR. HINNEFELD:** There aren't -- there won't be
25 too many AWEs that really get a full-blown what

1 we think of as a best estimate from Savannah
2 River.

3 **DR. WADE:** Mark -- excuse me -- do you want us
4 to have any information on the call that could
5 allow for the replacement of cases? Or would
6 you --

7 **MR. GRIFFON:** Let me first -- let me first --
8 I'll -- let me do the cross-walk and talk with
9 Kathy if I have any questions on that.

10 **DR. WADE:** Then let us know so we --

11 **MR. GRIFFON:** And then if there -- yeah, and
12 then -- then I'll let you know if -- if we need
13 to maybe pull -- have some cases available.
14 But it may be -- it may be that it's close
15 enough that we don't -- you know.

16 **MR. HINNEFELD:** Okay.

17 **MS. BEHLING:** Okay.

18 **DR. WADE:** Okay.

19 **MS. MUNN:** But especially if all of -- If
20 literally all of the cases that were on the
21 original list we had to choose from -- if too
22 many of them fall into the category that don't
23 fit our -- our need, then --

24 **MR. GRIFFON:** We may have to --

25 **MS. MUNN:** -- (unintelligible) --

1 **MR. GRIFFON:** Yeah, we don't want to waste our
2 time.

3 **MS. MUNN:** No.

4 **MR. GRIFFON:** Yeah, right. That was the whole
5 point of doing that, we don't want to waste our
6 time with --

7 **DR. MAURO:** We began work on the fifth set, I
8 mean, they're just -- they're moving forward.

9 **MR. GRIFFON:** Oh, okay.

10 **DR. MAURO:** Should we -- should we reign that
11 in?

12 **MS. MUNN:** That's fine.

13 **MS. BEHLING:** Oh.

14 **DR. WADE:** I would say no.

15 **MR. GRIFFON:** Yeah, I would say -- I would say
16 no. But -- let me -- I-- I'll look quickly at
17 this.

18 **DR. WADE:** Certainly look at the sixth one.

19 **MR. GRIFFON:** You haven't started on the sixth?

20 **MS. BEHLING:** The sixth -- I've done that also
21 but I haven't cross-walked that.

22 **DR. WADE:** But you haven't started working --

23 **DR. MAURO:** It's not actually doing work. We
24 haven't --

25 **MS. BEHLING:** But there's -- but there, I do

1 believe you've captured quite a few --

2 **MR. GRIFFON:** Yeah, I think -- I think the
3 sixth we were safer 'cause we were picking
4 mostly from best estimate cases.

5 **MS. BEHLING:** Yes. Like DOE sites.

6 **MR. GRIFFON:** Yeah.

7 **DR. MAURO:** The -- I think there may -- perhaps
8 this designation of best estimate, 'cause I was
9 surprised to see that, for example, we -- we
10 have a -- a Linde site was one of the -- in the
11 fifth set that I just finished, and I noticed
12 that the -- the whole dose is based on an
13 exposure matrix for Linde. One size fits all.
14 And I guess I was having a little -- and I see
15 that in the write-up you represent the matrix
16 as a best estimate. And there's something
17 about calling a one-size-fits-all a best
18 estimate that would apply to everyone that
19 worked at Linde just -- I don't know, there's
20 something about that I'm having a little
21 trouble getting my brain around.

22 **MR. HINNEFELD:** Well, let me just explain the
23 thought process and the choices you have as a
24 dose reconstructor, or as a reviewer, when you
25 approve a dose reconstruction. The choices you

1 can pick are full internal and external, which
2 is what we call best estimate; underestimate,
3 primarily internal; underestimate, primarily
4 external; underestimate, internal and external;
5 and then overestimate for those three
6 categories. And those are your choices. So
7 when you have a one-size-fits-all, you haven't
8 made any maximizing assumptions, you haven't
9 thrown in any extra -- you know, extra zeroes
10 in the missed dose, you haven't jacked up the
11 DCFs.

12 **DR. MAURO:** And so in that respect --

13 **MR. GRIFFON:** Let me understand.

14 **DR. MAURO:** -- you didn't do any of that.

15 **MR. HINNEFELD:** I haven't done a TIB-2
16 overestimating intake --

17 **DR. MAURO:** Yeah, you didn't do any of that.

18 **MR. HINNEFELD:** -- it's all --

19 **DR. MAURO:** It's all there.

20 **MR. HINNEFELD:** -- one-size-fits-all.

21 **DR. MAURO:** It's all there.

22 **MS. MUNN:** It's the best you can do.

23 **MR. GRIFFON:** Stu, I under-- I understand your
24 --

25 **DR. BEHLING:** But you know, in a loose sense of

1 the word, it does comply with the descriptions

2 --

3 **MR. GRIFFON:** John, was your -- was your point

4 that in the DR report that it was --

5 **DR. MAURO:** Yeah, the do-- the dose -- the

6 actual --

7 **DR. BEHLING:** -- (unintelligible) best estimate

8 you can get.

9 **MS. MUNN:** Best you can get.

10 **DR. BEHLING:** So, in a loose way, it does

11 satisfy the definition.

12 **MS. MUNN:** Yeah. That, of course, is not what

13 we're meaning in later cases when we have the

14 option.

15 **MR. GRIFFON:** That -- that's my -- I guess that

16 might be different in the DR report, if it's

17 characterized as a best estimate and --

18 **MS. MUNN:** Yep.

19 **DR. MAURO:** It -- it is.

20 **MR. GRIFFON:** And if you --

21 **MS. MUNN:** It's the best you can do.

22 **MR. GRIFFON:** I mean that -- that may be

23 something that you want to bring forward as a

24 finding -- I don't know, you know -- depending

25 on what you think of -- you know, whether you

1 think that mischaracterizes --

2 **MR. HINNEFELD:** Well, in a DR report we'll say
3 a case is an overestimate to indicate -- we've
4 done an efficiency method, an overestimate.
5 And we'll put in there words like "if the facts
6 of the case change we have to rework it" --

7 **MR. GRIFFON:** Right.

8 **MR. HINNEFELD:** -- "but dose may actually go
9 down because of the overestimating efficiency
10 techniques we used in this overestimating
11 approach."

12 **MS. MUNN:** Uh-huh.

13 **MR. HINNEFELD:** And in an underestimate --
14 we'll call an underestimate in dose
15 reconstruction an underestimate because we
16 don't use all the components of the dose and so
17 it won't look like others. But if we have a
18 one-size-fits-all exposure matrix --

19 **DR. MAURO:** You use it all.

20 **MR. HINNEFELD:** -- they're all going to do
21 that. You know, they're all going to come out
22 there and that's as fine as we've -- best we
23 can do.

24 **MR. GRIFFON:** That's the best you can do, so it
25 is a best estimate in a sense.

1 **MR. HINNEFELD:** It's just not a -- not a
2 complicated -- it's a really simple dose
3 reconstruction. It's not a complicated one
4 like a -- a best estimate at Hanford.

5 **MR. GRIFFON:** And that's part of why we want to
6 go down this path, is when we were looking for
7 best estimates we were looking for the more
8 complicated, you know --

9 **MR. HINNEFELD:** We could bring -- I mean, for
10 selection purposes, we could bring additional
11 information. If we have AWEs that are called
12 best estimates, we can come to the table saying
13 whether that AWE best estimate really was
14 relying on individual data, because we do have
15 some individual data from A-- some AWEs and we
16 could theoretically do some --

17 **DR. MAURO:** Not in this case.

18 **MR. HINNEFELD:** -- individual cases.

19 **DR. MAURO:** The one I'm looking at --

20 **MR. HINNEFELD:** No. No.

21 **MR. GRIFFON:** I think in the last round of
22 selection, you know -- I --

23 **MR. HINNEFELD:** Meaning the last time --

24 **MR. GRIFFON:** -- we kind of called on you
25 because I was, you know, saying -- when we were

1 picking uranium facilities I was saying isn't
2 this another one-size-fits-all?

3 **MR. HINNEFELD:** A lot of those uranium AWEs
4 that --

5 **MR. GRIFFON:** You were confirming that it was
6 -- yeah.

7 **MR. HINNEFELD:** -- were non-compensable you can
8 almost count on being TIB-4.

9 **MR. GRIFFON:** Right. Right.

10 **MR. HINNEFELD:** But there were some on there
11 that surprised me. There were some AWEs that I
12 thought would be a cookie cutter that we
13 actually had the exposure record on, and it was
14 generated off the exposure record. So in
15 selec-- I remember one in particular in the
16 sixth selection.

17 **MR. GRIFFON:** So let's -- let's -- I'll give an
18 update on five and six at the August 8th, but
19 don't hold up work, I agree.

20 **MS. BEHLING:** Okay.

21 **MR. HINNEFELD:** We -- we wouldn't hold up work.

22 **DR. BEHLING:** We're well into doing the audits.

23 **MR. GRIFFON:** Okay. All right. And I think
24 we're done. Is that a wrap?

25 **DR. WADE:** It's a wrap.

1 **MR. HINNEFELD:** Good by me.

2 **DR. WADE:** Well done. Thank you all.

3 **MR. GRIFFON:** Meeting adjourned at this time.

4 **DR. WADE:** We'll see you next in -- on the
5 phone call on August 8th, although there is a
6 working group meeting next Monday, Dr. Melius's
7 working group dealing with conflict of
8 interest. And maybe we'll see some of you
9 there -- or hear some of you there.

10 (Whereupon, the meeting was concluded at 3:00
11 p.m.)

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CERTIFICATE OF COURT REPORTER**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 day of July 27, 2006; and it is a true and accurate transcript of the testimony 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 9th day of September, 2006.

STEVEN RAY GREEN, CCR**CERTIFIED MERIT COURT REPORTER****CERTIFICATE NUMBER: A-2102**