

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes the

TWENTY-SIXTH MEETING

ADVISORY BOARD ON
RADIATION AND WORKER HEALTH

VOL. I

The verbatim transcript of the Meeting of the
Advisory Board on Radiation and Worker Health held at
the Shilo Inn Suites, 780 Lindsay Boulevard, Idaho
Falls, Idaho, on August 24, 2004.

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

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

(By Group, in Alphabetical Order)

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Purdue University
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3 Paper, Allied-Industrial, Chemical, and Energy Union
4 Local 5-4200
5 Miamisburg, Ohio
6
7 GRIFFON, Mark A.
8 President
9 Creative Pollution Solutions, Inc.
10 Salem, New Hampshire
11
12 MELIUS, James Malcom, M.D., Ph.D.
13 Director
14 New York State Laborers' Health and Safety Trust Fund
15 Albany, New York
16
17 MUNN, Wanda I.
18 Senior Nuclear Engineer (Retired)
19 Richland, Washington
20
21 PRESLEY, Robert W.
22 Special Projects Engineer
23 BWXT Y12 National Security Complex
24 Clinton, Tennessee
25
26 ROESSLER, Genevieve S., Ph.D.
27 Professor Emeritus
28 University of Florida
29 Elysian, Minnesota
30

31
32 AGENDA SPEAKERS

33
34 (in order of appearance)
35
36

37 Ms. Laurie Ishak, NIOSH
38 Mr. Pete Turcic, DOL
39 Mr. Tom Rollow, DOE
40 Ms. Liz Homoki-Titus, OGC
41 Dr. John Mauro, SC&A
42 Dr. Joseph Fitzgerald, SC&A
43 Dr. Jim Neton, NIOSH
44 Dr. Paul Ziemer, Chair
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NANCY LEE & ASSOCIATES

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Steven Ray Green, Certified Merit Court Reporter

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RICH, BRYCE L.
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SCHAUER, DAVID
TENFORDE, THOMAS S.
TOOHEY, R.E.

NANCY LEE & ASSOCIATES

P R O C E E D I N G S

(9:00 a.m.)

REGISTRATION AND WELCOME

1
2
3
4 DR. ZIEMER: Good morning, everyone. I'd
5 like to call the meeting to order. My name is
6 Paul Ziemer. I'm the Chair of the Advisory Board
7 on Radiation and Worker Health.

8 This is the 26th meeting of this Board.
9 We're pleased to be here in Idaho Falls. If
10 you'll indulge me, I'm going to begin with a
11 little story.

12 My first visit to Idaho Falls was in the mid-
13 sixties. I spent a week here early in my career,
14 and at that time had two daughters. I
15 subsequently ended up with four daughters, but at
16 that time I had two daughters and my wife and two
17 daughters accompanied me here. Now Linda, who
18 was at that time the youngest daughter, had a
19 special doll that went with her everywhere. And
20 if you think back to the mid-sixties, the popular
21 doll was a doll called Heidi-ho. So Linda
22 brought Heidi-ho with her and she -- we told her
23 where we were going and from that point on this
24 town became known as Heido-ho Falls. And even to
25 this day, when I told Linda where I was going

1 this week -- and Linda's in her forties now --
2 she said Oh, you're going to Heidi-ho Falls. So
3 we're pleased to be here in Heidi-ho Falls for
4 this meeting of the Board.

5 I need to give you several pieces of
6 information. First of all, we ask that everyone
7 -- Board members, staff people and members of the
8 public -- please register your attendance with
9 us. There's a registration book at the entryway.

10 If you haven't done that already, please do that
11 sometime this morning and we'll have a record of
12 your attendance here with us.

13 Also you will find on the table over here on
14 my far left copies of various documents,
15 including today's agenda, plus various handouts
16 from this meeting as well as documents from some
17 previous meetings of the Board, and please avail
18 yourselves of those material, as well.

19 If you're a member of the public and would
20 like to address the Board during the public
21 comment session, we ask that you sign up, also.
22 There's a sign-up booklet back there at the
23 registration table. The public comment period
24 today will be an evening session. It begins at
25 7:00 p.m. We welcome any of you who wish to

1 participate to do so at that time. The meeting
2 at that point is very informal, and you're
3 welcome to address the Board at that particular
4 point.

5 Also, I call your attention to the fact that
6 on the agenda for Wednesday, the second day of
7 this meeting, we inadvertently omitted the public
8 comment period from the agenda. We always have a
9 public comment period every day of our meeting.
10 And in addition to the evening public comment
11 session, we certainly welcome additional comments
12 for individuals who may not be able to attend
13 Tuesday evening. And you'll have to insert that
14 into the agenda. The plan will be to do the
15 public comment period Wednesday right after
16 lunch, so that would show up at 1:30, just prior
17 to the Board working session. So if you would
18 insert that in your agenda, please, and the time
19 for that will be dependent on the number of
20 individuals who sign up and wish to speak at that
21 point.

22 I believe that's all of the general
23 announcements and information that I have. I'm
24 not going to introduce the individual Board
25 members to the -- those who are here observing,

1 but you'll see the placards that have their names
2 and you'll be able to identify who the various
3 participants and members of the Board are.

4 I do want to, however, introduce the
5 Designated Federal Official, and that's Larry
6 Elliott. And Larry, I'll let you add any
7 comments you wish at this time.

8 MR. ELLIOTT: Thank you, Dr. Ziemer. On
9 behalf of the Secretary of the Department of
10 Health and Human Services, the Director of the
11 Centers for Disease Control and Prevention, and
12 the Director of NIOSH, I wish to welcome all the
13 Board members and the public to this meeting here
14 in Idaho Falls. We have a very full agenda and I
15 look forward to a productive and informative
16 session. Thank you.

17 DR. ZIEMER: As is usually the case, the
18 first item on the agenda refers to the minutes of
19 the last meeting, and some of the Board members
20 did not see these minutes until last night or
21 even this morning, perhaps, in some cases. The
22 minutes are rather lengthy -- 68 pages, small
23 print, singly-spaced. I ask the Board if you
24 wish to take action on the minutes now or, as has
25 become your custom, do you wish to defer action

1 until tomorrow's work session?

2 MR. ESPINOSA: Tomorrow.

3 DR. ZIEMER: I hear one tomorrow.

4 DR. MELIUS: Yeah, I -- definitely tomorrow.
5 I haven't even received them yet, so...

6 DR. ZIEMER: Okay.

7 DR. MELIUS: I have to catch up with my
8 materials.

9 DR. ZIEMER: They should be -- oh, you
10 haven't got your packet even?

11 DR. MELIUS: My packet, no.

12 DR. ZIEMER: Okay. It's probably at the
13 desk. We'll make sure you get it. Okay, we will
14 definitely defer action on the minutes until
15 tomorrow. Again I'll remind the Board members,
16 look particularly at those parts of the minutes
17 that -- where you are specifically identified as
18 making comments or making motions to make sure
19 that there's accuracy and a good reflection of
20 what was done, and we'll have an opportunity
21 tomorrow to take specific action on those
22 minutes.

23 PROGRAM STATUS REPORT

24 We'll move on then to the program status
25 report. This month's -- or this meeting's report

1 is going to be given by Laurie Ishak from NIOSH.

2 Laurie, we'd be pleased to hear from you now.

3 MR. ELLIOTT: While we're loading up her
4 presentation, let me introduce you to Laurie
5 Ishak. She is a Presidential Management Fellow,
6 just recently come to NIOSH in the Office of
7 Compensation Analysis and Support, and she's
8 serving as a communications specialist with us,
9 and I'm sure that you will see more of her in the
10 future.

11 DR. ZIEMER: And this is a test.

12 MS. ISHAK: I'll see if --

13 DR. ZIEMER: Thank you, Laurie. We're
14 pleased --

15 MS. ISHAK: -- I can pass with flying colors.

16 DR. ZIEMER: -- to have you here.

17 MS. ISHAK: Thank you. Well, good morning --
18 or for those of you still on eastern time, like
19 myself, I should say good afternoon. As Larry
20 mentioned, my name is Laurie Ishak. I am a
21 Presidential Management Fellow, a recent addition
22 to the OCAS team, and it's a pleasure to be here
23 this morning and I look forward to my future work
24 with both OCAS and the Advisory Board.

25 Now we'll move on to slide number two. As

1 you can see, slide number two represents the
2 amount of submittals from both the Department of
3 Labor and the OCAS rate of production. The blue
4 line is representative of claims received from
5 the Department of Labor. The green line
6 represents the number of draft reports to the
7 claimants, and the red line represents the final
8 draft dose reconstruction reports to the
9 Department of Labor.

10 I want to take a moment here to point out a
11 tremendously misleading visual effect of this
12 graph. This sharp downturn at the end of the
13 graph occurs because it only takes into account
14 up until August 13th, so it looks like there's a
15 drop-off right there at the end, but there really
16 isn't. We strongly anticipate that when the
17 numbers come in at the end of the month they'll
18 be consistent with the numbers from the previous
19 months. And with the green line we anticipate
20 not only consistent numbers, but we anticipate
21 much higher numbers, as well.

22 Now looking at the past few months you can
23 see by the green line that we have increased
24 production every month. And in April and in June
25 we broke the record of 500 dose reconstruction

1 reports sent to claimants. While it does fall
2 short of our goal of 200 dose reconstruction
3 reports to claimants a week, it does indicate two
4 important facts. One, our team is remaining
5 consistent. As you can see from the green line,
6 since March our team has steadily remained above
7 the 400 mark in dose reconstruction reports sent
8 to claimants. Secondly, as the green line
9 clearly indicates, over the last few months our
10 team is steadily increasing production every
11 month. So you see both consistency and progress.

12 Also, by looking at the blue line on this
13 graph you can see that the number that -- for the
14 most part, the number of submittals from the
15 Department of Labor is also decreasing. We're
16 averaging 200 to 250 claims a month from the
17 Department of Labor.

18 Now to mention the red line, you can see that
19 the number of final dose reconstruction reports
20 to the Department of Labor is also increasing.
21 However, it is important to note that OCAS has
22 little control over the red line. Once we send
23 out the dose reconstruction reports to claimants,
24 we cannot send a final report to the Department
25 of Labor until they sign the OCAS-1 form and send

1 it back to us. But overall you can still see
2 from the graph that the number -- the trend is
3 increasing.

4 So in summary of this graph, you can see that
5 as Department of Labor submittals decrease and
6 OCAS production increases, the gradual decrease
7 in backlog cases becomes an even more tangible
8 goal.

9 Now I move on to slide number three, which
10 shows the cases received from the Department of
11 Labor by district. As you can still see that
12 we've received the majority of our cases from the
13 Jacksonville district, which is -- includes both
14 the Savannah River Site and Oak Ridge National
15 Laboratories. Together those two sites combined
16 make up almost 6,000 claimants, so most of
17 Jacksonville's claims right here come from those
18 two sites.

19 You can see that Seattle comes in second with
20 5,186 claims; Cleveland comes in third, 3,485
21 claims; and you've got Denver coming in with
22 1,871 claims.

23 Now we move to slide number four. Slide
24 number four represents the number of the
25 Department of Labor cases received by quarter.

1 It's kind of a summary of the first line graph
2 that we saw and just presents the information in
3 a little different way for you. Now again let me
4 start out by pointing this visual discrepancy
5 here at the end of quarter four. Quarter four --
6 the fiscal year quarter four doesn't end until
7 September 30th, so there's going to be a lot more
8 information added there. So remember when you're
9 looking at this graph, it hasn't decreased. It
10 only includes numbers as of August 13th, so I'd
11 like you to keep that in mind.

12 But you can see, this chart starts out at
13 quarter one of '02 and goes through quarter four
14 of 2004, and you can see that there's a general
15 downward trend of cases received from the
16 Department of Labor.

17 Let's go on to slide number five. Like slide
18 number four, this slide represents the line graph
19 that I first showed you in a little different
20 way. Again -- I hate to harp on this matter, but
21 this little visual drop right here is only
22 because it only takes in the numbers for the
23 first two weeks of August. It doesn't mean that
24 production has dropped. And by the time we get
25 the numbers in at the end of August, we expect

1 those numbers to be as high, if not higher, than
2 the previous months.

3 I like this chart because it kind of shows
4 how hard we've been working. You can see that
5 between February and March there was a huge
6 increase in production, and you can see that
7 since April we have continuously increased
8 production every month. And in June we broke the
9 500 record of dose reconstruction reports sent to
10 claimants. In total we have sent 4,588 draft
11 dose reconstruction reports to claimants.

12 Now you can see here in slide number six --
13 again, same presentation of the information in a
14 different format than the line graph -- and this
15 represents the draft reconstruction reports -- I
16 mean the dose reconstruction reports sent to the
17 DOL monthly. And this chart, like I said,
18 coincides with the slide number two with the line
19 graph. And again you see that drop-off right
20 there, keep in mind it's only the first two weeks
21 of August and that's why you see that drop-off.

22 But you can see here that some -- to point
23 out again that OCAS has little control over the
24 bars on this graph because we currently have 400
25 to 500 average OCAS-1 forms out a month, so we

1 can't send any final dose reconstruction reports
2 to the Department of Labor until we get those
3 OCAS-1s back signed, and then send them off to
4 DOL. And we're averaging about 400 to 500 OCAS-1
5 reports out a month, so you can see the trend
6 there. And you can see that, while we don't have
7 much control over it, there's still a general
8 upward trend in the increase of the reports --
9 final reports sent to the DOL. And as of August
10 13th we have sent out 4,097 final draft dose
11 reconstruction reports to the Department of
12 Labor.

13 Slide number seven represents the DOE
14 response to requests for exposure records. As
15 you can see, we have sent out 16,653 requests for
16 exposure records covering 14,981 cases. At the
17 risk of pointing out the obvious, let me say that
18 the reason there are more requests than there are
19 cases is because many of our claimants may have
20 worked at multiple sites. Therefore you might
21 have more requests than you do what represents
22 the actual cases.

23 The responses from the DOE total 15,985
24 covering 14,226 cases. Again, more requests
25 because claimants may have worked at multiple

1 sites. I also want to point out that the slide
2 uses the word responses received, and not
3 necessarily information received. And that's
4 important to remember because sometimes when we
5 get responses back from the DOE there may not be
6 information about exposure history on there. But
7 these are the number of responses we've received
8 from the DOE.

9 And on the bottom you can see the age of
10 outstanding requests. Anything 60 days or more,
11 90 days or more, 120 days or more, 150. And as
12 an FYI, for the site that we're at now, the
13 number of requests that we've sent to DOE for
14 Idaho National Engineering Laboratory -- we have
15 sent out 669 requests for exposure history. We
16 have received from the DOE 651 responses, which
17 equal about 90 percent of the requests that we
18 sent out. There are 18 requests outstanding for
19 greater than 60 days, which equates to about 3
20 percent of the requests we sent for the Idaho
21 site.

22 All right, slide number eight pretty much
23 breaks down the telephone interview statistics.
24 Here you can see cases for which at least one
25 interview has been completed is 16,230. And you

1 can see "one" is emphasized because in several
2 claims you might have multiple claimants and
3 therefore more than one interview has to be
4 completed. But you can still see that there's a
5 large majority of cases where we've completed one
6 interview.

7 And then the interview summary reports sent
8 to claimants, you can see the drafts equal almost
9 22 hundred (sic) -- 21,813. And currently we're
10 doing about 200 to 300 interview -- telephone
11 interviews a week, with about 20 staff members
12 working on that.

13 We now have slide number nine, and slide
14 number nine breaks down the number of telephone
15 interviews conducted by month as of August 13th.

16 The blue bars represent 2002, the yellow bars
17 are representative of 2003, and then you have the
18 green bars which represents 2004. Again, this
19 chart shows that we are currently achieving
20 approximately 200 to 300 phone calls a week on
21 the telephone interviews.

22 All right. Slide number ten provides you
23 with the dose reconstruction statistics as of
24 August 13th. The first bullet shows you that
25 there are 5,123 cases staged for dose

1 reconstruction, "staged" meaning that ORAU has
2 gone through the file and that the DOE response
3 has been received and a profile has been done.

4 The second bullet highlights that there are
5 1,466 cases that have been assigned for dose
6 reconstruction. The assigned number of cases
7 differ from the staged number of cases because
8 while the file on its face might look complete,
9 the information is actually not complete. For
10 instance, the DOE response may not have any
11 information on exposure history, or the site
12 profile might not be complete for that individual
13 claimant.

14 Now the third bullet shows you that the dose
15 reconstruction draft reports sent to claimants is
16 at 4,588, and then the final DR reports sent to
17 claimants, DOL and the Department of Energy is
18 4,097.

19 Now this next chart breaks down the number of
20 cases completed by NIOSH tracking numbers, and
21 you can see the tracking numbers ranging along
22 the bottom from 1,000 to 17,000. Now we're
23 currently working with ORAU to reduce the cases
24 with numbers below 5,000 by 20 percent in the
25 next ??? period. There's a group at ORAU who's

1 actually working on these cases going through
2 case by case to see why they can't be completed
3 and to try to complete those in a timely manner.

4 Now I move to the next chart which shows the
5 amount of administratively closed records as of
6 August 13th. As you can see, the numbers are
7 relatively small -- along the top there -- and
8 most of the-- or all of these become -- the dose
9 reconstruction becomes administratively closed
10 when we don't receive the OCAS-1 forms back. Now
11 remember, we don't have the authority to close a
12 case. We only close the dose reconstruction
13 process, send that to DOL and it's their
14 responsibility whether or not to then
15 administratively close a case.

16 Now the next graph I have here, slide number
17 13, depicts the number of reworks that we're
18 getting back from the Department of Labor.
19 Currently that number is staying at 7 to 8
20 percent a month being sent back to be reworked.
21 The green bars are representative of the dose
22 reconstructions received from the Department of
23 Labor to be reworked, and the blue bars represent
24 the reworks that we finish and send back to the
25 Department of Labor.

1 Now it looks like on this chart -- and it may
2 not be obvious. It looks like on this chart that
3 the numbers of reworks is increasing because
4 obviously the green bars are increasing. But
5 what's not apparent from this chart is that we're
6 also sending more reports to the Department of
7 Labor, which means that the percentage is still
8 staying the same. We're still getting about 7 to
9 8 percent back, not that we're getting back any
10 more reworks than we were getting before. So the
11 percentage is really what matters, and I don't
12 think that's too obvious from this chart so I
13 wanted to point that out.

14 Now let's look at slide number 14 -- we're
15 kind of moving into a new area here -- the SEC
16 petitions. As you are probably aware, the final
17 rule 42 CFR 83 was published on Friday, May 28th,
18 2004. And this rule describes the process
19 through which HHS will consider designating
20 classes of employees to be added to the Special
21 Exposure Cohort rule (sic).

22 Now the requirements for classifying a group
23 under the SEC are intended to ensure that
24 petitions are submitted by authorized parties,
25 are justified and receive uniform, scientific and

1 fair consideration. You can see here that we
2 received the first petition on June 15th, 2004,
3 and that was actually personally handed to Larry
4 Elliott at the meeting in Burlington, Iowa, so a
5 little bit of background information on that
6 first petition. Now we have nine active SEC
7 petitions as of now.

8 Now you can see on the next slide what the
9 breakdown is of these nine petitions. We have
10 one from the Hanford site, three from the Iowa
11 Ordnance Plant, one from K-25 at Oak Ridge, one
12 from Los Alamos, one from Mallinckrodt, one from
13 Paducah, then we have one various multiple
14 facilities rounding out the nine active SEC
15 petitions we have.

16 Now the SEC petitions that we have are
17 currently in the process of being qualified,
18 making sure that they qualify as a SEC petition,
19 and we work with the claimants to make sure that
20 it's done right. Under 42 CFR 83.6 through 83.11
21 there's a detailed process through which a
22 claimant has to go through to file a petition
23 under the SEC as an SEC class. Now we work with
24 those groups to make sure that they're providing
25 all the information, so there have actually been

1 several conferences -- phone or e-mail -- with
2 some of these claimants to make sure that they're
3 getting in the petitions in the format to meet
4 the current rule.

5 Also you can see that for each qualified
6 petition, once it becomes qualified, then we
7 publish a notice in the Federal Register which
8 will notify the public of NIOSH's decision to
9 evaluate a petition. Now remember, it's a
10 multiple-step process. First we have to qualify
11 the petition. Now that's not saying once we
12 qualify the petition that it becomes an SEC
13 class. We're just saying that the petition, on
14 its face, is appropriate and then qualified.
15 Then we provide a notice to the public, and then
16 we go through the process of seeing if it
17 evaluates or if it qualifies as an SEC class.
18 And again, all of our petitions are currently in
19 the process of being qualified.

20 And then lastly, all qualified petitions will
21 be evaluated by NIOSH in accordance with the
22 provisions of 83.13 or Section 83.14.

23 All right. This last slide number 17 shows
24 the number of phone calls and e-mails received
25 from OCAS -- or received to OCAS and ORAU. Now

1 you can see that OCAS is receiving -- or has
2 received 32,276 phone calls, and you see that
3 ORAU has 111,616 phone calls. And there's also,
4 you know, a big discrepancy between those two
5 numbers, and a lot of that occurs because it is
6 ORAU's responsibility to conduct the telephone
7 interviews, so they're going to be getting more
8 phone calls trying to set up these telephone
9 interviews, conducting the telephone interviews
10 and doing follow-up calls concerning the
11 interviews. And most of the OCAS phone calls
12 that we receive are status requests, people
13 wanting to find out the status of their claim.
14 And this last number -- last bullet will show you
15 the number of claimant e-mails to OCAS is at
16 3,466.

17 This next chart is going to point out some of
18 our accomplishments, and the first thing I want
19 to point out is that the number of final dose
20 reconstruction reports sent to the Department of
21 Labor exceeds 4,000 now. It's hit its milestone
22 of 4,000 and continues to grow, and as of today
23 we've sent out more than 4,000.

24 You can also see that we have sent out
25 activity reports. We're still doing that. We

1 sent out over 19,000 activity reports in July.
2 And the activity reports, just to refresh your
3 memory, is -- the first two page-- it's about
4 five pages, typically. The first two pages are
5 claimant-specific information where it gives the
6 claimant information about their specific case.
7 And then the next three pages are hot topics, if
8 you will. Every claimant gets pretty much the
9 same in the last three pages, and it covers
10 information that maybe a lot of claimants have
11 called in about to the PHAs or something that we
12 want to share with the claimants. And like I
13 said, we sent out over 19,000 of those in July.

14 We also continue to have the web-based status
15 requests from claimants. We started that
16 program, setting up the status base, in March.
17 And since then we get about two to three web-
18 based requests for status a day. Since then
19 we've sent back 73 denials for requests. What
20 happens is they might not have the specific
21 information because of the Privacy Act. The
22 status-based -- web-based status request requires
23 specific information, and if they send the form -
24 - the request without giving us specific
25 information, we cannot send them back the

1 information. But Chris Ellison, our
2 communications specialist, looks over each of
3 those denials personally to make sure that we
4 can't actually give them the information and that
5 the computer's not making some sort of error.
6 Then we send back a denial and, you know, telling
7 them that they're missing some information, and
8 then they have every chance to send back another
9 web-based request for status -- or to call in, as
10 well.

11 And we also have -- I want to add a point
12 here that's not on the slide of accomplishments.

13 Actually I have two more to add in here, and the
14 first one is that under subsection (d) of the
15 EEOICPA -- I still get tongue-tied on that one --
16 under subsection (d) it's our responsibility to
17 appoint physician panel -- or physicians to the
18 panel for the Department of Energy. So far we
19 added 73 new physicians, bringing the total over
20 300 physicians that we have appointed.

21 And then I also want to mention that we have
22 worked with ORAU to change our conflict of
23 interest policy. Now it includes site profiles,
24 as well. So if somebody has worked at a site and
25 they're conducting the site profiles, the lead

1 site -- person doing site profile cannot have
2 worked at the facility where the site profile is
3 being done, and that's a recent addition to our
4 conflict of interest, which -- make it a little
5 stronger.

6 And then we also have OCAS staffing updates.

7 We had a few changes here, including myself.
8 We'll go through this quickly. This is the OCAS
9 organizational chart. The yellow squares
10 represent positions that are filled. Then you've
11 got the white spots, white boxes where there are
12 open positions that you can see on this chart.

13 First I'd like to announce that Jim Neton has
14 moved from Technical Program Manager to the
15 Associate Director for Science, as you can see on
16 that chart, and Jim will be monitoring existing
17 and emerging scientific issues relating to dose
18 reconstruction and risk models.

19 We also have two new fellows to the program.

20 First Heidi Deep is -- joined us as the ASPH
21 Fellow, and the second you have myself, Laurie
22 Ishak, joined as a Presidential Management
23 Fellow, so you have two new fellows added to the
24 program.

25 There are also ongoing interviews for the

1 research epidemiologist and the health
2 communications specialists. The announcement for
3 the Technical Solutions team leader has been
4 closed, and there's also going to be two new
5 positions for health physicists and one for the
6 technical program manager to replace Jim after
7 his move.

8 So that concludes my program status report
9 and I am open for any questions that the Board
10 may have concerning some of this information.

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

13 DR. MELIUS: Yeah, I have several questions.

14 On the DOE -- requests for information from DOE,
15 some of the past meetings you've presented
16 information on which sites have the largest
17 backlog. You didn't this time, though. Could
18 you tell us -- update us a little bit on -- there
19 were some sites that have been problematic in the
20 past and it seems to me the numbers have gone
21 down, so -- just trying to figure out if that's
22 across the board or if there are still particular
23 sites where there are difficulties getting
24 information from.

25 MS. ISHAK: Well, I received some information

1 as of August 15th, 2004. I think typically the
2 numbers are going down. I know that there was a
3 problem with the Los Alamos National Laboratory
4 sites, and of course I wasn't a part of the last
5 meeting, but I'm not sure if that's the site you
6 may be referring to, and there was a database
7 problem with that site. We have currently worked
8 with the DOE with the Los Alamos site and we've
9 kind of corrected some of the problems, so that
10 should be speeding up the requests that sent out
11 there for that information.

12 Now I have -- my list is kind of long. Is
13 there any site-specific questions --

14 DR. MELIUS: Well --

15 MS. ISHAK: -- or are you just asking for a
16 general trend --

17 DR. MELIUS: -- just -- no --

18 MS. ISHAK: -- and some of the problem sites?
19 I know it was Los Alamos, but that's been --

20 DR. MELIUS: Yeah, particular --

21 MS. ISHAK: -- corrected.

22 DR. MELIUS: -- sites.

23 MS. ISHAK: Okay.

24 DR. MELIUS: If you could share that maybe
25 for future updates, just -- it would be easier if

1 we could just see the presentation that's -- you
2 know, matches up with what we've received before.

3 MS. ISHAK: Okay.

4 DR. MELIUS: I also have a question on the
5 backlog issue and this program -- I think you
6 talked a little bit about last time, also -- or
7 Jim Neton did -- about this program to focus more
8 resources on the early cases. Now again I think
9 you've made some progress on those cases, but not
10 a lot, and you seem to -- it seems where you get
11 stuck around -- you get a quarter of the cases
12 done in each thousand and then it seems to slow
13 down. And I don't know how many are out -- how
14 many are out for review and so forth so that the
15 number actually may be higher. It may be a third
16 of them or something. But what -- what's the
17 process and -- and so forth? It seems to me that
18 you're doing 20 percent a quarter for those first
19 -- seems to me you're not getting at those very
20 easily. I know it's hard, but I'd be curious how
21 you're doing that.

22 DR. NETON: Laurie, if you don't mind, I'll
23 field that question.

24 MS. ISHAK: Okay.

25 DR. NETON: We are aggressively pursuing the

1 backlog and -- and in particular the cases with
2 numbers -- ID numbers 5,000 or less. Laurie
3 mentioned that we have incentivized (sic) ORAU,
4 in the last performance award ??? period which
5 ends this September 11th, to reduce the backlog
6 of claims below 5,000 by 20 percent. We believe
7 they're on target in doing that and are going to
8 be very close, if not meeting that -- that
9 incentivized goal.

10 Starting September 11th will be the two-year
11 anniversary of the contract of ORAU and we are
12 working closely to develop the incentive language
13 for the next six months, and it will be heavily
14 incentivized to eliminate the backlog below
15 5,000. In other words, we're going to try to
16 continue to complete all the cases below 5,000.
17 Now whether that's a reality or not, I don't
18 know. There may be some issues -- and this may
19 come -- become a little clearer when I talk about
20 some of the things that we're doing with ORAU to
21 develop coworker profiles and such so that we can
22 start attacking those cases. 'Cause frankly, up
23 until this point, we haven't had the technical
24 tools, the ability to work those cases and that's
25 why they're sitting.

1 DR. MELIUS: Okay. Wouldn't some of those --
2 if I could just continue on this -- wouldn't some
3 of those cases also be SEC candidates because --
4 I mean at what point are you going to, you know,
5 determine that you can't do a dose
6 reconstruction? I mean you're going to make them
7 wait until --

8 DR. NETON: Well --

9 DR. MELIUS: -- you know, till you've
10 exhausted all...

11 DR. NETON: Well, I would -- I'm kind of
12 getting into my presentation on tomorrow --

13 DR. MELIUS: Then that -- then that's fine --

14 DR. NETON: -- relating to certain dose
15 reconstructions.

16 DR. MELIUS: -- if you'd rather -- if you
17 want to answer that tomorrow, that's fine. I
18 don't --

19 DR. NETON: I think I'd be better prepared in
20 the context of my presentation.

21 DR. MELIUS: That's fine. That's fine. I'm
22 just raising the questions that came up now.

23 DR. ZIEMER: Do you have any additional
24 questions?

25 DR. MELIUS: Somebody else can go if they

1 want --

2 DR. ZIEMER: Henry has --

3 DR. MELIUS: -- but I may have some more.

4 DR. ZIEMER: Okay. Henry?

5 DR. ANDERSON: You were first.

6 DR. ZIEMER: I'm sorry, I didn't see -- Mark
7 Griffon, then Henry.

8 MR. GRIFFON: I have one just -- just
9 preliminary one, which is you gave a lot of case
10 statistics -- claims and case statistics.

11 MS. ISHAK: Uh-huh.

12 MR. GRIFFON: But I didn't see -- you
13 mentioned how many dose record requests have been
14 made for Idaho, but you didn't mention how many
15 claims have been submitted for Idaho and I
16 thought that the audience might be interested in
17 that -- claims for Idaho and the completed cases
18 for Idaho.

19 MS. ISHAK: I actually don't have that
20 information with me. It is on our public web
21 site.

22 DR. NETON: (Off microphone) Those two
23 numbers (Inaudible) or whatever.

24 MS. ISHAK: Okay, equal to the DOE requests,
25 and those numbers --

1 DR. NETON: (Off microphone) (Inaudible)
2 cases.

3 MS. ISHAK: Okay. If you'd like to hear them
4 --

5 MR. ELLIOTT: I think -- I think Pete Turcic
6 will speak to the statistics locally and
7 regionally, as well as nationally, so I think
8 that's where you'll find -- you'll get his
9 presentation and I think that's -- we were
10 relying on him to present numbers like that.

11 DR. ANDERSON: Yeah, my question is, it
12 looked as though -- where you're processing about
13 500, it seemed, dose reconstructions a month, and
14 do you see that as kind of now the -- your basic
15 status? I mean are you up to speed and sort of
16 running ahead at what you'd do is be kind of
17 maintenance mode of this -- this is what your
18 plan is and that's -- that's where you're at and
19 now it'll just continue along at that, or are you
20 -- is the goal of -- to get it up to how many
21 a...

22 MS. ISHAK: Well, our original goal and still
23 our goal is 200 a week. And we finally hit the
24 500 mark, which we see as clear progress. And I
25 think that, seeing the charts from the previous

1 months, that getting to 500 was an
2 accomplishment. And then of course we would like
3 to get to 200 a week, and I think that we're
4 moving towards that way. Again, we expect the
5 numbers in August to be a little bit higher than
6 they were from even the previous month, so I
7 think the trend upward is not only what we're
8 hoping for but what we're expecting in the next
9 few months.

10 DR. ANDERSON: So you do expect it to -- to
11 ramp up to the --

12 MS. ISHAK: We do.

13 DR. ANDERSON: -- 800 a month, about,
14 roughly. Yeah.

15 MS. ISHAK: That's what we're aiming at.
16 We're expecting that climb up there, and I think
17 the trend shows that's where we're getting. So
18 we went from 200 to 400 to 500, and --

19 DR. ANDERSON: Yeah, yeah, it seemed to be
20 sort of that -- 500 and I wondered if you'd --

21 MS. ISHAK: Yeah, we expect that to --

22 DR. ANDERSON: -- reached sort of a -- yeah.

23 MS. ISHAK: -- go up, clearly. Clearly
24 expect it to -- and like I say, we expect the
25 numbers for August --

1 DR. ANDERSON: That's a lot of paper.

2 MS. ISHAK: -- we expect the numbers for
3 August to be higher, as well.

4 MR. ELLIOTT: We hope that this is not a
5 plateau.

6 DR. ANDERSON: Yeah, that's what --

7 MR. ELLIOTT: It's our full expectation to
8 reach 800 a month or 200 a week. And if we can't
9 do that, we're asking serious questions as to why
10 and trying to investigate exactly what is
11 preventing that accomplishment from -- from being
12 recognized and achieved.

13 DR. ZIEMER: Gen Roessler.

14 DR. ROESSLER: I think Mark was ahead of me.

15 MR. GRIFFON: Go ahead. I've got another
16 one, but...

17 DR. ROESSLER: Laurie, your last slide was
18 informative, but I have two questions about it.
19 This is the organizational --

20 MS. ISHAK: The organizational chart?

21 DR. ROESSLER: Yes. One is -- it would be
22 helpful I think to the Board to see names
23 associated with those boxes so that when we hear
24 presentations we can see where the person fits in
25 with the organizational chart.

1 It would also be helpful -- now I can read
2 that, but I can't read it in the notebook. Maybe
3 I need new glasses, but --

4 MS. ISHAK: It was difficult to get all those
5 boxes --

6 DR. ZIEMER: You know what that's a sign of
7 though, don't you?

8 DR. ROESSLER: I know that's what --

9 DR. ZIEMER: Okay.

10 DR. ROESSLER: But most of us are in that
11 position, probably, so it would be helpful to
12 have this chart readable as a handout, and with
13 names on it as much as you --

14 MR. ELLIOTT: We will provide that. We will
15 provide you a chart you can read and we'll have
16 names in the boxes.

17 MS. ISHAK: It's hard to get all those boxes
18 on a slide. We worked a long time on that.

19 DR. ZIEMER: I want to interject here -- I'll
20 take my prerogative as Chair to interject a
21 question. On the nine or ten SEC petitions -- is
22 it nine?

23 MS. ISHAK: It's nine --

24 DR. ZIEMER: Nine?

25 MS. ISHAK: -- active.

1 DR. ZIEMER: Can you remind us of the time
2 table when -- when your review is -- on adequacy
3 is completed, what's the time period in the
4 Federal Register and what's the time period
5 before the Board sees these? The procedure calls
6 for the Board to review all these petitions, and
7 when will we expect them to first hit the Board?

8 MS. ISHAK: I think Larry better would answer
9 that question right now.

10 MR. ELLIOTT: That was not a planted
11 question, but it was a welcomed question. Yes,
12 we're -- we're dealing with nine right now. We
13 actually have a total of 13, but those -- the
14 others are representative of requests that were
15 sent to us by mail before the rule passed, and
16 some of those are duplicate of the nine.

17 We are diligently working hard at evaluating
18 all nine, at the same time qualifying all nine.
19 As Laurie pointed out, we -- the first step in
20 the process is to work with the petitioners to
21 qualify the information that is initially
22 presented and make sure that it is in the form
23 required by the rule to move it to the next step.

24 I anticipate and I expect -- and I'm fairly
25 adamant in this expectation -- that at your

1 October Board meeting in San Francisco -- prior
2 to that Board meeting we'll announce in the
3 Federal Register that several petitions have been
4 qualified and are proceeding under research
5 evaluation and a research evaluation report will
6 be presented to the Board in October at your
7 meeting in San Francisco. It's my expectation,
8 my anticipation, that the -- two of those nine
9 are very critical to us because we've done a lot
10 of work on those two sites, the Iowa Plant site
11 and Mallinckrodt site. And as you know, in our
12 site profiles we had sections reserved where we
13 had minimal, if any, data. And so that gave us
14 an advantage and a leg up to start our work in
15 evaluating those particular profiles and -- with
16 regard to whether a class should be established
17 for those two sites.

18 At the same time, we're not sacrificing the
19 other petitions. We're working on those in an
20 evaluation effort at the same time as
21 qualification, so I think for Mallinckrodt we'll
22 be presenting to the Board a research evaluation
23 report that speaks to the early years, the 1942
24 to '46 years, and -- and I hope to see that
25 announced in Federal Register before the Board

1 meeting and we will present that evaluation
2 report for the Board's review and comment and
3 decision in October.

4 The Iowa site presents us a little bit
5 different set of problems in that the information
6 that we're seeking to evaluate for that
7 particular petition and a class that might come
8 out of the Iowa site is constrained by national
9 security information. We need our Q-cleared eyes
10 on that information to determine its relevance,
11 or lack of relevance, to the petition. And I'm
12 fully prepared and ready -- as the rule provides,
13 at my discretion -- to determine that it may not
14 be a timely retrieval of information if it's
15 bound by security constraints to move forward
16 with a designated class for that particular
17 facility.

18 So just to give the Board some insight into
19 your future endeavors here in October, I fully
20 expect that you'll be seeing one, if not more,
21 evaluation report on SEC petitions.

22 DR. ZIEMER: Thank you. Mark, then Roy and
23 then Jim.

24 MR. GRIFFON: This question's related to
25 some-- Jim just gave a response about making up

1 for the backlog, and I guess the phrase that
2 struck me was he said that there will be --
3 "heavily incentivized" I think is the term he
4 used, or heavy incentives for clearing that
5 backlog. I'm wondering if that means a contract
6 modification with ORAU and -- and is ORAU
7 currently within -- within their existing -- you
8 know, we had a five-year budget, I guess, that
9 ORAU had initially. Are they currently operating
10 within budget, over-budget, you know, sort of --
11 I was wondering what the status was on...

12 DR. NETON: Okay, there's two questions
13 there. The first question is what did I mean
14 when I said heavily incentivized, and I guess
15 maybe I -- heavily is relative term, I suppose.
16 What I meant by that is ORAU's contract is --
17 includes a provision for a cost plus an award
18 fee. That award fee is awarded every six months
19 or evaluated every six months, and there's a pot
20 of money available based on some pre-set amounts
21 when the contract was awarded. The higher the
22 score, the higher the total number of dollars out
23 of a total work fee that they can receive.

24 The cost plus award fee provision is in the
25 contract, but -- so it does require a

1 modification every six months if we do tweak it.

2 But we anticipated that when the contract was
3 awarded that we could not have a generic set of
4 award fee every six months to be meaningful. You
5 know, for instance, the first award fee period we
6 had had a lot of information related to start-up
7 -- start-up timeliness and that sort of thing.
8 So in this last period we have modified the
9 contract to incentivized by more award fee points
10 directly tied to finishing cases below 5,000. I
11 can't -- I can't give you a dollar figure or
12 anything, but that -- that's the -- that's the
13 idea behind that.

14 And in the next six-month award fee period
15 we're going to more heavily incentivize finishing
16 cases below 5,000, in addition to incentivizing
17 reaching 200 dose reconstructions per week. So
18 that's -- that's what that's about.

19 MR. ELLIOTT: If I could add to that, this
20 current cost performance award fee that we have
21 negotiated with their contractor addresses not
22 only the backlog of the first 5,000 cases and
23 trying to get those cleared and answers given,
24 rightfully so, to the claimants, it also
25 addresses this rework stream -- process stream,

1 if you will -- which was not in the previous cost
2 performance award fee and we felt it needed to be
3 recognized, it needed to be incentivized, and it
4 is a separate process stream that we don't want
5 to overlook or miss. So when reworks come back
6 to us from the Department of Labor -- and I want
7 to make a comment on why we're getting reworks.

8 In a lot of cases -- the majority of the
9 cases it's because the claimant -- the
10 circumstances of the case have changed. Another
11 cancer has been recognized and diagnosed or
12 additional employment has been developed by the
13 Department of Labor, and we have to factor that
14 back into a revised dose reconstruction. The
15 minority of those reworks deal with how we did
16 our work. And I don't have a percentage on that,
17 but it's a very small -- small percentage.

18 The other incentivized aspect of this
19 performance award fee that we're currently
20 working under deals with our goals, our
21 Government Performance Results Act -- GPRA --
22 goals, our -- our program target goals of 200 a
23 week, trying to get 8,000 -- at least 8,000 done
24 in a year's time. I know those two numbers don't
25 equate, but -- but we are -- we're -- we're

1 incentivizing 200 a week to get to 800 a month,
2 with the hope that by the end of a year's worth
3 of time we can show progress and hopefully
4 achieve 8,000 completed in a year's time. And as
5 you see, we're not there yet.

6 So we've tried to put those incentives before
7 our contractor and we'll continue to modify these
8 performance award fees on a six-month basis to
9 try to target aspects of the program that need
10 attention and -- and devotion and energy.

11 DR. NETON: Okay, I think that answers the
12 first question. The second question was where is
13 ORAU in relation to their original budget
14 estimates in the contract. They have gone over
15 fairly significantly in cost on this contract in
16 relation to the original budget. We are in a
17 process right now of renegotiating where -- where
18 that might be, but I don't have the figures
19 available with me to discuss where they're at in
20 particular, but -- but they will be over-budget.

21 DR. DEHART: Roy DeHart. The question I have
22 goes back to the SEC petitions. Among those
23 activities or sites was K-25, and K-25 is already
24 recognized as an SEC site. I was wondering if
25 there's any clarification as to why another

1 application -- or is it premature to even begin
2 to ask that question at this point?

3 MS. ISHAK: My -- Jim, did you want to answer
4 this question or...

5 DR. NETON: Yeah. I don't recall the
6 specifics, but it's more than likely related to
7 covered exposure outside of certain time periods.

8 I mean I think K-25 had -- you know, the SE--
9 the original SEC sites had certain prescribed
10 time constraints, and I think it is either
11 outside of that -- it must be related to that.
12 That's the only condition I can think of that
13 would...

14 DR. ZIEMER: Jim?

15 DR. MELIUS: Yeah, I have two questions. One
16 quickly, the conflict of interest on the site
17 profiles for ORAU, is that the same conflict of
18 interest policy as exists for the other -- for
19 the -- you sort of described it briefly, but is
20 it the same as for the other dose
21 reconstructions?

22 DR. ZIEMER: I think Jim Neton can --

23 DR. NETON: Yes, I'll answer that. This was
24 just signed I believe Friday, very timely. It
25 took some going back and forth, and -- you know,

1 legal --

2 DR. ZIEMER: Incentivized.

3 DR. NETON: -- folks involved, but in essence
4 what we've done is it's exactly -- ORAU has
5 placed language in their conflict of interest
6 policy that is -- parallels almost exactly the
7 exact language for the dose reconstructions. And
8 in fact, we took the opportunity at this time,
9 since we had it opened up, to add the same type
10 of provisions for evaluation of SEC petitions.
11 So you know, we were trying to be a little
12 proactive there and be ahead of the curve, so
13 principal reviewers on SEC petitions cannot have
14 previously been employed at the site and that
15 sort of thing. It's out there on our web site.
16 I have copies that --

17 MR. ELLIOTT: Aren't the copies in the
18 Board's book?

19 DR. NETON: They should be in your book under
20 my site profile presentation.

21 MR. ELLIOTT: Okay.

22 DR. MELIUS: Second question has to do with
23 the SEC petitions. Are those going to be -- do
24 you have a task order with ORAU for doing the
25 technical work on those or are those being done

1 internally? What's the plan on that?

2 DR. NETON: Oak Ridge Associated Universities
3 is -- is doing the bulk of the work on this.
4 They are actually performing almost all the
5 technical work. But NIOSH, just like with the
6 dose reconstructions, maintains full
7 responsibility and review over the final product.

8 We work very closely with them. It's an
9 iterative process, very much like dose
10 reconstructions. Drafts come over, we vet them
11 internally and review them and cycle them through
12 the process. But they have right now -- I
13 believe there's up to a dozen health physicists
14 available to work on the SEC process within ORAU.

15 Now they're not all actively working right now
16 because the work load's not there. But they have
17 been identified as sort of a matrix type process
18 that they'll be available to work on them.

19 DR. MELIUS: So that's a separate task within
20 the contract, or -- I'm just --

21 DR. NETON: Yeah, the original contract
22 itself -- I mean the title of the contract was
23 dose reconstruction and SEC petitions or
24 something. What's happened now is ORAU, to track
25 cost and progress under that task, has created a

1 task ten within their organization that will --
2 Dave Peterson*, a former NIOSH employee, is
3 heading up that task for ORAU and so it's tracked
4 as a separate task at this point.

5 DR. MELIUS: And so that won't -- it's not
6 going to be a problem in terms of contract issues
7 (Inaudible) --

8 DR. NETON: No, this was totally envisioned
9 within the scope and the budget of the original
10 contract language.

11 DR. MELIUS: Okay. Do that. I don't know if
12 now's the time, but it certainly may be during
13 the work session. We as a Board are going to be
14 presented with SEC petition, you know, review --
15 I forget what you call it; evaluation, I guess --
16 at our next meeting. We need to, I think, sort
17 of think through how we're going to review that
18 and what procedures we want in -- in place and so
19 forth, and I'd certainly like to talk about that.

20 DR. ZIEMER: During our work session we can
21 address that issue specifically. I think it's
22 appropriate that we do so.

23 Incidentally, as we talk, a copy of the ORAU
24 team conflict of interest policy now has been
25 distributed to the Board members, a document

1 dated August 23rd. And I presume these are also
2 available to the public if -- if others wish to
3 see them, so they'll be on the table.

4 Okay, additional questions? Laurie, thank
5 you very much.

6 MS. ISHAK: Thank you.

7 DR. ZIEMER: You have passed the test and --

8 MS. ISHAK: That's good to know. I'll sleep
9 well tonight. Thank you.

10 STATUS AND OUTREACH - DEPARTMENT OF LABOR

11 DR. ZIEMER: The Chair feels like we've
12 barely gotten underway and the schedule already
13 calls for a break, but we're a little ahead of
14 time. I'm going to exercise the prerogative in
15 suggesting that we proceed with Pete Turcic's
16 presentation, if that's okay with Pete.

17 So, status and outreach report on -- from the
18 Department of Labor, Pete Turcic. Pete?

19 MR. TURCIC: I just want to give you an
20 update on the status of the program at the
21 Department of Labor, and to date we've gotten up
22 to -- we've now exceeded 57,000 claims. And of
23 that, the largest proportion, again, remains to
24 be cancer claims, with some 40,000 -- over 40,000
25 cancer claims. Beryllium sensitivity has kind of

1 leveled off at about 2,500. We get very few
2 beryllium claims anymore, as well as the chronic
3 beryllium disease. It kind of leveled off at
4 3,700. Silicosis remains at about 1,100 claims,
5 and RECA has stabilized at about 6,200. Most of
6 our RECA claims now are reworks that the
7 Department of Justice is doing on previous
8 claims, you know, under the new regulations.
9 They modified some regulations. And fortunately
10 our -- the category of non-covered conditions,
11 that has -- we've seen a dramatic drop in that
12 and we're attributing a lot of that to, you know,
13 some of our outreach efforts where we tend to --
14 we don't get as many -- anywhere near as many
15 non-covered conditions as we used to.

16 Looking at the overall -- the status of the
17 overall cases, the status -- the pending cases at
18 NIOSH, there's been a significant reduction
19 there, showing that we're down to 12,490 cases at
20 -- at NIOSH. And pending at our district offices
21 we have a working inventory of about 2,600 claims
22 at any given time. And pending a final decision,
23 the claims of -- the claims that have received a
24 recommended decision, awaiting a final decision,
25 either a hearing or a review of the record, is

1 about 2,300. And we've made final decisions
2 issued in nearly 25,000 cases now of the total of
3 42,000 cases that we have received.

4 Some of the program statistics, the
5 recommended decisions -- and again, the split --
6 to date we've had, you know, nearly 14,000 claims
7 -- recommended decisions to approve benefits and
8 22,000 to deny benefits. Final decisions, 13,000
9 to approve and about 18,000 to deny. And
10 payments issued, 11,600 payments for -- in 875 --
11 nearly \$875 million of benefits and nearly \$40
12 million in medical benefits paid.

13 DR. ZIEMER: Pete, while that slide is up,
14 could I interrupt --

15 MR. TURCIC: Sure.

16 DR. ZIEMER: -- since the slide is here,
17 could you clarify now on the final decisions, the
18 13,046, for example, that's a subset of the
19 13,800 --

20 MR. TURCIC: That's correct.

21 DR. ZIEMER: Okay. And likewise on the
22 denies then?

23 MR. TURCIC: Well, it's -- it's -- that is a
24 subset, but there could be a few cases -- there's
25 not a whole lot, but there may be a recommended

1 denial, but then when it goes to a final
2 decision, it's reversed at the FAB, but that's a
3 very small number.

4 DR. ZIEMER: Thank you.

5 MR. TURCIC: The breakdown of -- and this --
6 there is some changes in -- in this chart. This
7 is starting to change some. The final decisions
8 to approve, 13,800; 18,000 to deny -- the non-
9 covered conditions as a reason for denials, that
10 has been going down. In fact, in -- in the last
11 year it's been probably less than 2,000 added in
12 that category. And naturally the cancer -- the
13 1,922 cancer not related, the POC of less than 50
14 percent naturally has been, you know, going up.
15 And -- now this gets to also the issue on the
16 backlog. As I said, there's been a significant
17 reduction in the backlog. But we've been --
18 we've been averaging in the neighborhood of 200
19 to 300 cases per -- you know, claims a week, and
20 with the non-covered conditions going down, you
21 know, that means that of those 200 or 300 cases,
22 more and more will be, you know, going in for
23 dose reconstruction as time goes on. So that's,
24 you know, something to think about as time goes
25 on and whether the 200 is going to -- a week will

1 really cut into the -- into the backlog.

2 The status of the NIOSH referrals -- again,
3 4,597 cases have been returned from NIOSH with
4 4,375 with completed dose reconstructions and 222
5 did not need dose reconstructions. Cases with --
6 of those, cases with recommended decisions, 733
7 recommended decisions to approve benefits and
8 2,686 to deny benefits. Of those having final
9 decisions, 660 with final acceptances and 1,534
10 with final denials, and 80 -- about \$87 million
11 have been paid in benefits in compensation from -
12 - directly from cases from NIOSH with dose
13 reconstructions, so that's -- that's starting to
14 grow dramatically and increasing now on a weekly
15 basis.

16 Now just look at what happened in the last
17 year -- as it turned out, the Ohio meeting was
18 about the same time -- and to show what -- I mean
19 I think we want to really compliment NIOSH on a -
20 - on a job well done and what was achieved. In
21 that last year, from -- since the Ohio meeting,
22 DOL -- we sent an additional 3,400 cases to NIOSH
23 for dose reconstruction. NIOSH returned 41 --
24 over 4,100, so that made a significant reduction
25 in the -- in the backlog that NIOSH needs to be

1 complimented on.

2 Of those, the recommend-- in the last year
3 the recommended decisions, 618 to accept benefits
4 and 2,539 to deny. Final decisions, 560 to
5 accept and 1,496 to deny, and that's what the
6 status of the -- what happened over the last --
7 the last year, since last August.

8 Now I just want to take some time to maybe
9 give a better understanding -- now that we have,
10 you know, thousands of cases that have come back
11 and gone through the process -- of what happens
12 because I don't think there's -- you know, I
13 think it would be good for the Board to
14 understand what happens when a claimant gets a
15 recommended decision based on a dose
16 reconstruction and what can they appeal. And so
17 once we get a case back from NIOSH and we've been
18 meeting our goal -- our goal is to, once we get a
19 dose reconstruction back from NIOSH, to issue a
20 recommended decision within an average of 21 days
21 after receipt of that dose reconstruction report,
22 and we've been exceeding that standard. So we
23 have been -- we -- we have been issuing -- we've,
24 you know, recommended decisions in -- within
25 three weeks after receiving a dose reconstruction

1 report.

2 At that time the claimant is given the
3 opportunity -- they can request the -- a hearing,
4 an oral hearing. If they so choose, but only if
5 they choose, the hearing can be a telephone
6 hearing. They can request a review of the
7 written record and state objections. Or they can
8 waive objections. And if they waive objections,
9 then we immediately process the claim. Usually
10 that's an acceptance. We'll process it and in a
11 very short period of time we can, you know, have
12 a final decision and issue -- issue payment.

13 And to explain what happens in the review
14 process, the review of the dose reconstructions
15 at our Final Adjudication Branch -- first let me
16 just talk about the scope. And again, this is
17 all in the regulations. The regulations specify
18 what portions -- what is the scope of the review
19 that the Final Adjudication Branch would do on a
20 objection of a dose reconstruction.

21 Number one, we will look and it is DOL's
22 responsibility to adjudicate factual information.

23 And that's very important because, you know, for
24 consistency and, you know, lot of -- lot of times
25 claimants will claim that something happened.

1 Well, there has to be a -- we have to weigh that
2 evidence, and there has to be some probative
3 evidence, some reason and rationale to accept
4 that as a factual piece of information. So we
5 will accept objections on factual information.
6 You know, if a claimant comes in and says an
7 incident occurred or a practice occurred, NIOSH
8 did not address it in the dose reconstruction, we
9 will adjudicate that issue and we will weigh the
10 evidence and make a determination of the veracity
11 of that evidence and whether that evidence is
12 accepted or not accepted.

13 Then we also look at the application of
14 methodology, and that's a fine line between --
15 there's a fine line between application of
16 methodology and actual methodology. But the
17 methodology is basically a regulatory issue and
18 would need -- an objection to it needs to be
19 handled through the normal channels of, you know,
20 objecting to a regulation. The normal court
21 channels of, you know, here's what NIOSH put in
22 the regulations; here's the methodology that is
23 used. If there's an objection to that, that
24 challenge needs to go to a court. That challenge
25 cannot be addressed in the final adjudication

1 process. However, the application -- you know,
2 it could be -- they can come in and argue that
3 the wrong model is used. And then we would go to
4 NIOSH, we would look and make sure and -- and
5 again, any factual information, any objections
6 raised are addressed -- would be addressed in the
7 final decision.

8 Based on those objections, the potential
9 outcomes is that the -- at -- the Final
10 Adjudication Branch could affirm the recommended
11 decision. They could reverse the recommended
12 decision. Now they cannot reverse a payment, so
13 the rules that go on that is that the claimant --
14 the FAB would never take an acceptance, reverse
15 that to a non-acceptance, without doing another
16 recommended decision that would explain in detail
17 why the denial so that the claimant could object
18 to that denial.

19 But there have been cases where -- you know,
20 if it's a denial -- recommended denial, the FAB -
21 - goes to the FAB; it could be reversed, made
22 into a -- an acceptance, without going back to
23 the claimant. And most -- most frequently, if
24 there is an issue, it would be remanded, either
25 to the DOL district office for another

1 recommended decision, or to NIOSH for handling
2 some issue.

3 More than likely it would be a factual issue.

4 If a claimant made a factual objection, the FAB
5 accepted that factual objection, we would remand
6 that case back to NIOSH -- and that is some of
7 the reworks. But like, you know, Larry pointed
8 out, most of the reworks are a new cancer, a
9 second cancer was diagnosed, you know, in the
10 intervening time. But there have been some
11 remands where it would be remanded because the
12 claimant was able to raise a factual situation, a
13 set of facts that we would then remand it back to
14 NIOSH to have a rework to address that set of
15 factual information.

16 And then naturally the claimant -- at that
17 point in time, at the final decision, they do
18 have a further review -- appeal. They have the
19 option -- at that point in time they have 30 days
20 in which they could ask for a reconsideration.
21 Now a reconsideration would be that that case
22 would go to a separate -- a different claims
23 examiner, hearing rep, who would re-look at the
24 whole case and make sure that they would come up
25 with the same conclusion as the first hearing

1 rep.

2 After that, they can request a reopening to
3 my office, and it is a discretionary reopening.
4 It could be -- well, they have a year to show,
5 you know, new information, but there's no time
6 limit on -- at any time then I have the
7 discretion to reopen any case based on new
8 information or if situations, you know, have --
9 have changed.

10 Just a review of some of the objections that
11 we have gotten to this point, so far -- and this
12 is in the last year, in FY 2004, so it's not even
13 a whole year -- we've received requests -- 420
14 requests for hearings. We have conducted 311
15 hearings. We've received 653 requests for review
16 of the written record, and that's where the
17 claimant may file an objection but just ask for a
18 review of the record. And to date we've done 567
19 of those. And we've received 2,925 waivers of
20 objections.

21 And here you can see what's happening with
22 our hearing -- requests for hearings. As you can
23 see, our requests for hearings are increasing as
24 -- as we expected. And to be quite honest -- I
25 mean prior to this last year, most of our

1 hearings were -- I object that, you know, heart
2 disease is not a covered illness. Now we're
3 starting to get a lot more substantive, you know,
4 objections and requests for hearings. And NIOSH
5 just did a great job of a training of some of our
6 hearing reps with a more in-depth training and
7 explanation of the dose reconstruction process so
8 that they'll be able to better address those
9 issues when they come up in the hearing process.

10 DR. ZIEMER: Pete, just a question here from
11 Larry.

12 MR. ELLIOTT: Are all 420 of these dose
13 reconstruction cases specifically?

14 MR. TURCIC: That's the majority, but there -
15 - there would be a few that, you know -- that
16 might be RECA cases or -- or beryllium.

17 The waivers -- again, it's pretty constant.
18 We've got -- been getting about 1,000 waivers a
19 quarter.

20 The NIOSH cases that have been remanded, just
21 to cover some of those issues -- total remands,
22 328. Recommended decisions -- of those, 75 had
23 recommended decisions to approve benefits, and so
24 far 36 of them have remained as final approvals.

25 Then there were 263 that were recommended

1 decisions to deny, and to date the status of
2 those, two of them have been changed from a
3 denials to final approvals, 37 remain final
4 denials, 216 are still pending final decision, so
5 that means that they've been remanded. They're
6 either back at the district office for further
7 development -- it may be development of
8 employment, it could be development of a -- you
9 know, there -- there could be a -- we could have
10 gotten an indication that another cancer -- so
11 there could be medical development, it could be
12 employment development or it could be, you know,
13 sent back to NIOSH for -- for a rework for some
14 other reason. And eight of them have -- are
15 cases that were closed or withdrawn. Most of
16 those would be that the claimant has passed away
17 and there -- we're in the process -- either in
18 the process or we cannot find a survivor.

19 And just briefly and, you know, maybe at a --
20 at another meeting if you -- if you want, I can
21 go into, you know, more details -- just some of
22 the issues that we are getting at the hearing
23 level, objections at the hearing and review of
24 the written record on dose reconstruction cases.

25 Probably the vast majority were that information

1 was provided in the interview and not addressed.

2 To date, the vast majority of those are that it
3 -- the issue was addressed in the dose
4 reconstruction. It -- we probably, you know,
5 need to do a better job of, you know, putting a
6 few sentences to explicitly say how, you know, so
7 really, you know, the claimants may not be able
8 to read -- if you're not a health physicist, you
9 may not be able to see how it was, but it -- it
10 really -- vast majority of the cases, that they
11 were.

12 There have been several cases that it was
13 not, and those cases have merely been remanded
14 for NIOSH to rework and to address that -- that
15 specific issue. So here -- this is an example of
16 a factual situation where, you know, the process
17 -- there's a process to address these issues and
18 work through them.

19 We have a number where cases -- objection
20 have been made saying that unmonitored dose was
21 treated as missed dose, and we're working through
22 a -- through a number of those cases to -- to see
23 and -- you know, exactly what the status and --
24 and whether that's the case. And there -- there
25 -- again here, you know, oftentimes it's a

1 confusion as opposed to, you know, whether
2 something was done or -- or how it was done.

3 In several locations we got objections that
4 exposure from ingestion was not addressed. And
5 again, the final -- you know, one case that I'm
6 aware of that it really was, because of the --
7 you know, the monitoring, the -- the biological
8 monitoring, so that would be addressed -- in a
9 case like that, that would be addressed and
10 explained -- further explained in the final
11 decision addressing that objection. Each of the
12 objections in our final decisions are addressed
13 specifically.

14 Another -- we get incidents were not
15 addressed, and again, the process -- I don't, you
16 know, have the breakdown but I'd be glad to give
17 a more detailed explanation at a future meeting.

18 Another one that's growing is inappropriate
19 cancer model used. Now that goes directly to
20 methodology. You know, that's a direct
21 methodological issue, and so -- I mean we would
22 adjudicate the por-- the part that -- what was
23 the diagnosed cancer, was it appropriately --
24 based on the diagnosed cancer, the ICD-9, was
25 that all appropriate, and then how does that, you

1 know, fit in -- you know, into which model needs
2 to be used.

3 And one that we're -- this is a new one that
4 we're, you know, working with NIOSH on, and
5 what's happening is in the use of the efficiency
6 model, the worst-case scenario, sometimes it goes
7 to such an extreme and -- I mean that's another
8 issue that we need to look at, that are we
9 getting assumptions that are really too far in
10 the other direction. And you know, that really
11 gets to accuracy, also. But an issue we're
12 dealing with now is -- and procedure and how
13 we're going to come down on a policy issue is
14 that when you get -- you may get a 40 percent or
15 more based on efficiency model. Then another
16 cancer is diagnosed. You send it back for a
17 rework. NIOSH does a rework, now they're no
18 longer maybe using the efficiency model and now
19 the combined comes out at 20 percent, of the two
20 cancers. So that's an issue we -- we have a
21 number of objections raised on that we're working
22 through.

23 And just briefly, some of the statistics from
24 the local area, 1,179 cases filed; 40 recommended
25 decisions to approve, 487 to deny. Final

1 decisions, cases -- 37 to approve, 395 to deny.
2 There have been 14 payments made and -- for
3 compensation of \$2.1 million.

4 The status of the NIOSH referrals, 707 -- 153
5 have been returned. Of those, nine have been
6 accepted -- have recommended decisions to accept,
7 114 recommended decisions to deny; eight with
8 final decisions to accept and 51 with final
9 decisions to deny.

10 Looking at the denials, the number of denied
11 cases -- now this is total, it's not just the
12 dose reconstruction -- is 395 cases have been
13 denied. Of those, 51 were because the
14 probability of causation was less than 50
15 percent; 235 were the conditions was not covered;
16 48, the employee was not covered; 53,
17 insufficient medical evidence; and eight that the
18 survivor was not eligible.

19 And with that I'd take any -- try to answer
20 any questions you might have.

21 DR. ZIEMER: Thank you, Pete. Let's open the
22 floor now for questions. Richard, then Jim.

23 MR. ESPINOSA: In concerns of the outreach,
24 I'm just wondering what the Department of Labor
25 is doing to get out the word of the SEC rule?

1 MR. TURCIC: Of the SEC rule?

2 MR. ESPINOSA: Yeah.

3 MR. TURCIC: We've -- naturally we've talked
4 about any -- any outreach meetings, any public
5 meetings we have, we talk about the SEC petition
6 route. But we have not had any outreach that
7 targeted specifically and only SECs.

8 DR. MELIUS: Interested in a little bit more
9 information on this issue -- I guess you call
10 them remands and Larry calls them reworks.

11 MR. TURCIC: Uh-huh.

12 DR. MELIUS: I think they're roughly the
13 same. Is that --

14 MR. TURCIC: No, no, they're -- like Larry
15 said, most -- most -- a rework -- usually a
16 rework would be a situation such as an additional
17 cancer diagnosed, and basically it would be just
18 to send it back so that that additional cancer
19 could be included in the dose reconstruction.

20 A remand would be -- there's a factual --
21 information that may have changed or a call made
22 on a factual situation, and then that would be
23 sent back to include that specific -- and address
24 that specific issue.

25 DR. MELIUS: So then the -- that was for --

1 some of the confusion. The data that Larry -- or
2 was presented here about -- from the NIOSH
3 program on reworks, does that include the remands
4 or is that --

5 MR. TURCIC: Probably.

6 DR. MELIUS: Okay.

7 MR. TURCIC: And that's relatively new. I
8 mean this is something new.

9 DR. NETON: I'd like to address that issue
10 'cause I deal every day with these. The real
11 cut-point in my mind is a rework is typically
12 before even a recommended decision goes out.
13 Oftentimes we'll send over the dose
14 reconstruction. In the time -- from the time
15 that it was sent to us for dose reconstruction,
16 gone back to the claims examiner, they're making
17 a recommended decision, they notice that an
18 additional cancer has come up or the employment
19 is different or anything like that -- this is
20 before the claimant ever sees a draft dose
21 reconstruction or a recommended decision.

22 Once it goes to recommended decision, though,
23 then you get into the remand area where a
24 statement of factual accuracy has been challenged
25 or something like that.

1 MR. TURCIC: And the remands can take a
2 multi-faceted -- you know, there could be a
3 number of things that require a remand to NIOSH.

4 For example, if there is something in the
5 medical evidence that would indicate a -- say a
6 cancer that was not originally identified, then
7 in the final decision process that information
8 comes out, that could be remanded to the district
9 office to further develop the medical evidence
10 and then return it to NIOSH for a dose
11 reconstruction for that new -- that additional
12 cancer. Or it could be that the district office
13 counted employment that they shouldn't have, or
14 did not count employment that they should have.
15 And again, that same process. So the -- the
16 reason for the remand could be, you know, a -- a
17 number and it could be something that happened at
18 the DOL district office, it could be a change in
19 a situation or it could be a change in the
20 factual information.

21 DR. MELIUS: But I think -- well, I
22 understand that. I think -- there are a couple
23 of areas, though. One Larry mentioned earlier,
24 or someone did, in terms of there -- there are
25 some quality assurance issues that you're dealing

1 with with -- NIOSH is dealing with their
2 contractor. And so I'm assuming some of these
3 are -- someone's not doing something right or
4 something's getting through the system. Is that
5 -- I'm trying to get a handle on -- I think those
6 numbers are small, but you implied that it was a
7 growing issue and that --

8 MR. ELLIOTT: Well, I was indicating that in
9 our cost performance award fee, incentive there,
10 there -- we had -- we drew attention to what we
11 were calling reworks.

12 DR. MELIUS: Yes.

13 MR. ELLIOTT: When ORAU sees them, they don't
14 know whether it's a remand or a rework. Not all
15 remands -- or not all reworks are remands. If we
16 catch it during our review or we catch it in
17 conversation with the claimant during the OCAS-1
18 phase, before they sign it, we deem that as a
19 rework. If DOL has the case and it's a
20 recommended decision and it's caught at that
21 point, it's a remand and it becomes a rework if
22 it's brought back to us for rework.

23 DR. MELIUS: Right.

24 MR. ELLIOTT: So -- does that help? I mean -

25 -

1 DR. MELIUS: No, it helps. It's just that
2 we're mixing a lot of numbers here and it's --

3 MR. TURCIC: Yeah.

4 DR. MELIUS: -- there's different levels at
5 which -- some of it's new factual information.
6 Some may be errors that are made in the process -
7 - doing that.

8 I would also be interested in further
9 information -- maybe this is for another meeting
10 -- on some of these what I call more policy-
11 related issues where there's this -- the one you
12 mentioned with the additional primary cancer
13 causing some difficulties. I don't know if --
14 are there other sort of -- that are --

15 MR. TURCIC: Yeah, I --

16 DR. MELIUS: -- issues that are -- that
17 you're having to decide that -- that, you know,
18 reflect on the dose reconstruction process.
19 We've had some earlier issues with the -- I don't
20 know if it -- it was one of -- it was the third
21 question I usually get to ask and now down to
22 two, and is the -- is the issue with phosphate
23 processing and so forth with -- you know, what is
24 a -- exposure related to this program as opposed
25 to an industrial exposure and how that gets

1 counted.

2 MR. TURCIC: Yeah, those are policy, Jim, and
3 that -- and exactly -- we're still trying to work
4 out the policy framework to apply and to have our
5 FAB apply in these cases where the -- you know, a
6 second cancer may end up the combined POC less
7 than the -- you know, the first, using the
8 efficiency model. And so we're looking at, you
9 know, what -- what assumptions and what can
10 happen to assumptions as it goes through that --
11 as it goes through that process.

12 MR. ELLIOTT: This is a very complicated
13 issue right here. I mean -- and I want to make
14 sure everybody in the audience understands what
15 we're talking about.

16 Through our efficiency measures, when we
17 attempt in that effort to show that it's totally
18 unreasonable that a cancer was caused by a
19 radiation dose experience, let's say -- and let's
20 take prostate for example. I started seeing some
21 cases coming through in my review queue that were
22 at 40 percent for prostate, 44 percent. I
23 started raising a flag. I raised it with ORAU, I
24 raised it with DOL. I talked to Pete and I said
25 we've got to get our eyes on this because I am

1 concerned that we're going to see a case or two
2 come back at us from the FAB, after a recommended
3 decision, where additional cancer has been
4 identified and we go back and reconstruct a dose
5 on the prostate and the new cancer and our new
6 probability of causation resulting from that
7 reconstruction is lower than what the claimant
8 saw in their first report, and we need to be very
9 cognizant of this as a concern to the claimant
10 and confusion to the claimant. Because we're
11 trying in our first attempt, through efficiency,
12 to show that it takes a lot of dose to get a
13 prostate cancer over the 50 percent bar. And so
14 if we come in at 44 percent and then we have a
15 skin cancer, and then we resharpen our pencil and
16 do a reconstruction on both cancers and it comes
17 back out at 38 percent, they're going to go
18 "What?" So that's the issue and that's what
19 we're dealing with and we're working together to
20 try to make sure that we avoid confusion among
21 the claimants, get our point across, make sure
22 the science supports the dose reconstructions
23 that we're doing.

24 We're concerned, as Pete indicated, what our
25 assumptions are in the efficiency process when we

1 see a non-radiogenic cancer come in with a
2 relatively high POC that might be truly a lower
3 POC if we'd done, you know, the full-blown dose
4 reconstruction to get down to a very accurate, if
5 you will, probability.

6 DR. MELIUS: Well, just -- I guess -- at
7 least I, and I don't know if other members of the
8 Board would, but I think some discussion of that
9 at the Board level 'cause -- does it relate back
10 to the process to what's in our regulations,
11 whatever, and it also I think goes -- sort of the
12 other side of this issue of sufficient accuracy.

13 We've been -- you know, as relates --

14 MR. TURCIC: We'll have a --

15 DR. MELIUS: -- to the SEC.

16 MR. TURCIC: By -- by the next Board meeting
17 we should have a precedent case on that issue,
18 and I'd be more than glad to say at least where
19 DOL has come out on it and what the precedent-
20 setting case --

21 DR. MELIUS: And maybe --

22 MR. TURCIC: -- established.

23 DR. MELIUS: Yeah. Maybe if NIOSH -- you
24 know, if you could present also and where --
25 where these issues are coming up and -- what is

1 it, sort of new factual information, when is it
2 new -- is this efficiency issue.

3 DR. ZIEMER: Thank you. Roy DeHart.

4 DR. DEHART: Just a point of clarification on
5 the NIOSH case -- cases that are reprimanded
6 (sic) to them. In the slide you showed 328 cases
7 that had been forwarded to them and that 75 of
8 those cases had gone to a decision for approval.

9 Is it NIOSH that is making that decision?

10 MR. TURCIC: No, what that means is that of
11 those cases 75 started out as a recommended
12 approval, then it was remanded. Of all -- of all
13 those cases, of all the remands, 75 of them was a
14 recommended decision to accept benefits. It was
15 then remanded by the -- by the Final Adjudication
16 Branch.

17 DR. DEHART: So something had happened in the
18 review in Department of Labor that questioned --

19 MR. TURCIC: Exactly.

20 DR. DEHART: -- the approval.

21 MR. TURCIC: Exactly.

22 DR. ZIEMER: And this is before the claimant
23 sees the recommended decision.

24 MR. TURCIC: No, the claimant would have seen
25 the recommended decision.

1 DR. ZIEMER: Would have seen it.

2 MR. TURCIC: Yeah. It could be a number of
3 things. I know that we've had cases where the
4 district office used the incorrect ICD-9 code for
5 one of the leukemias.

6 DR. ZIEMER: So this makes it a little more
7 difficult for you since the claimant has seen the
8 recommended --

9 MR. TURCIC: Right, exactly, so we had to --
10 we had to remand back because, based on the code
11 that the district office used, the incorrect
12 code, then the incorrect model was used for the -
13 - for the IREP. Once the --

14 MR. ELLIOTT: Or the organ was --
15 reconstructed to the wrong organ. We do not
16 develop the claim with regard to the cancer
17 diagnosis. That's the Department of Labor's
18 responsibility. They give us a set of developed
19 facts and that's what we're required to use in
20 our work. And if that changes once the -- the
21 claim has gone back over to DOL and they've --
22 they have a different set of eyes look at it,
23 whether it's at the FAB level or at the
24 recommended decision level by another new claims
25 examiner, that could get kicked back to us.

1 MR. GRIFFON: I think I have a fairly
2 straightforward question. From early in your
3 presentation you -- you mentioned that your
4 backlog had significantly gone down, and I was
5 just wondering what the current backlog is of
6 cases, and how do you define backlog? Is it more
7 than 30 days old, more than 60 days old or --

8 MR. TURCIC: No, what -- what -- what I was
9 referring to there was the cases pending at
10 NIOSH.

11 MR. GRIFFON: Oh.

12 MR. TURCIC: If you look the previous year,
13 that's down by, you know, nearly 1,000 cases.

14 MR. GRIFFON: Well, how about the -- how
15 about the other question, your claims received
16 backlog, is there --

17 MR. TURCIC: We have --

18 MR. GRIFFON: -- a backlog --

19 MR. TURCIC: No, ours --

20 MR. GRIFFON: -- there?

21 MR. TURCIC: Ours is just a working -- we're
22 at the point where we have a working inventory;
23 99 percent of our cases have either a NIOSH
24 referral or a recommended decision within well
25 less than 120 days. So the 20 -- we -- we

1 normally have about 2,300 to 2,500 cases at any
2 time that are under development. You know, the
3 cases come in and, based on the 200 to 300 a
4 week, you know, you're talking about less than a
5 three-month working inventory.

6 DR. ZIEMER: Tony.

7 DR. ANDRADE: Yes, a quick question. When a
8 second cancer's -- is diagnosed and that comes up
9 as new information, is this sent back to be
10 reviewed by a physician as to whether or not it
11 is likely that it was metastasized from the first
12 cancer?

13 MR. TURCIC: Yeah, all -- we -- when we say a
14 second cancer is diagnosed, then that -- as part
15 of that diagnosis, that must be a primary. We
16 don't send metastasis -- the only time we would
17 send metastasis to NIOSH would be if it was a
18 metastasis of unknown primary, and then, you
19 know, the procedures are that they would run all
20 the potential -- all the probable primaries for
21 that given metastasis.

22 DR. ANDRADE: Then I would just like to
23 submit this statement for the Board to consider,
24 perhaps chew on. There are many processes that -
25 - that are -- workers have been involved in. A

1 lot of those involve manufacturing and processing
2 of materials that include both chemicals and
3 radiation. And so primary cancers can result
4 from either chemical toxicity and/or radiation.
5 Hence, even though we try to be very clear and
6 very meticulous in reviewing these cases, it
7 seems to me that that's always going to be a
8 questionable -- that's always going to be a
9 question mark. And that is perhaps one reason
10 why I submit we will never ever really be fully
11 satisfied that we can differentiate between the
12 two and, because you use efficiency measures in
13 one case, it tends to -- it tends to build a gray
14 area. And if you -- if you do have to go back
15 and do a rework, I can understand why a POC may
16 actually come down and be lower.

17 MR. TURCIC: Absolutely, uh-huh.

18 DR. ZIEMER: Thank you very much. It's time
19 for us to take our break. We'll recess for 15
20 minutes.

21 (Whereupon, a recess was taken.)

22 STATUS UPDATE - DOE PART D PROGRAM

23 DR. ZIEMER: We're ready to reconvene. The
24 next item on our agenda is a report from Tom
25 Rollow of Department of Energy. We're pleased to

1 have Tom with us again. Tom is going to report
2 specifically on the subpart D program, which is
3 the DOE's worker assistance program, I think is
4 the terminology. So Tom, we're pleased to have
5 you back with us today.

6 MR. ROLLO: Good morning. Thank you. While
7 Jim Neton -- well, I was going to say while Jim's
8 getting this set up I'll tell you a short story,
9 but I'll tell you the story anyway.

10 I spent most of my 30-year career working in
11 the safety business. I started out the first
12 half of my career working for the father of
13 nuclear power. I was on Admiral Rickover's staff
14 in Washington, D.C. And even though we did
15 nuclear design work and nuclear operations,
16 anybody that ever worked in the Rickover program
17 knows that safety is job one. And in the latter
18 half of my career I have the opportunity to work
19 for DOE, about the last 14 or 15 years, in the
20 safety office doing safety things. And so I have
21 a hard time walking into a room without looking
22 for things like fire exits and stuff.

23 And so when I walked into this room today and
24 the first thing I did -- this drives my wife
25 crazy when we go to dinner parties -- but the

1 first thing I did today was I walked in and I
2 surveyed the doors, and I think of things like
3 okay, if you go through that door, what's behind
4 that door? Is there a hallway and a 50-foot run
5 this way and then out to the left? What's behind
6 that door, which looks like -- sounded like a
7 loading dock when the truck backed up so I think
8 we're okay to get out that door over there.

9 When I figured out all the fire exits, my
10 mind started wandering to the ceiling, and I
11 looked at these light fixtures. Anybody want to
12 take a guess how much those might weigh? I think
13 it's fortunate that the room is set up this way,
14 that most of the weight would land on the floor,
15 not on the chairs. Except for --

16 DR. ZIEMER: They're very light. That's why
17 they're called "lights".

18 MR. ROLLOW: Thank you, Dr. Ziemer. I'm
19 going to give you a status today of Part D or
20 Subtitle D of the EEOICPA program. This is of
21 course the sister program to Part B, which most
22 of your attention is addressed towards. This
23 program covers the Department of Energy operated
24 program, which is aimed at providing assistance
25 to apply for Workers Compensation, and generally

1 includes not only the illnesses that the Part B
2 program includes, but is extended to any
3 illnesses caused by toxic substances.

4 I apologize for the size of the print here.
5 Hopefully most of the Board members are sitting
6 close enough that you can actually read this. I
7 noticed in the handouts not only would you need a
8 magnifying glass, but you'd probably need some
9 trifocals to read it in the handouts. But for us
10 it's all about production. It's been about
11 production for a year and a half. The bottom
12 line is that we feel that DOE now has a good
13 handle on production and we are moving along and
14 cooking pretty good right now, and so I wanted to
15 share with you some of these observations.

16 The right-hand side in the box is our weekly
17 statistics. They're actually on our web site.
18 If you're ever interested you can go to our web
19 site and look at these on a weekly basis. But we
20 are still producing positive and negative
21 physician panel determinations at a little over
22 100 a week. We are preparing cases for panel --
23 cases currently in the physician panel process
24 are cases going to panel, we're preparing those
25 at over 100 cases per week and we've hired a lot

1 of employees over the past couple of months.
2 I'll show you the -- kind of paint the picture
3 for you as to -- as to how that sets up, and we
4 expect to be at well over 300 cases prepared for
5 panel this fall, in the next probably four to six
6 weeks. And we expect to be -- our goal is to be
7 -- be issuing -- get -- getting cases back from
8 physicians panels in excess of 100 cases per week
9 right now, and moving that up above 300 cases per
10 week by next June. And it looks like right now
11 we'll greatly exceed that goal and I'll talk a
12 little bit about that, also.

13 The bottom line on this slide is that there's
14 about three categories up there that have to do
15 with case preparation. And we basically develop
16 cases in this part of the process -- the process
17 kind of goes from bottom to top, the top being
18 completed. We develop cases and send them out to
19 the applicants and allow the applicants 30 days
20 to look at the case file to see if they want to
21 add anything or make any changes to it. And
22 there's also a 15-day review in there for the
23 employer. But the case is basically developed
24 and the DOE work is largely completed at that
25 point.

1 The next step in the process as you move up
2 this chart is cases currently in the physicians
3 panel process. They're either at the physicians
4 being reviewed or they're in a queue waiting to
5 go to the physicians, and you can see there
6 there's another 3,000 some-odd cases in that
7 category.

8 And then there's cases completed, and of
9 course cases are completed by either finding
10 people not to be eligible or they have a positive
11 finding or a negative finding, are generally the
12 categories. And if you add all those up, DOE has
13 -- has processed or completed its work -- largely
14 completed its work in over 7,000 cases. We have
15 of course 25,000 total applications to date for
16 this program. That's kind of the big picture.

17 Let me just show you something graphically
18 here because it's all about resources. And as I
19 talked to you before, DOE underestimated the
20 scope of this program early on. And you know,
21 other organizations also shared in that
22 underestimation -- not to make excuses, but we
23 didn't -- we didn't rustle up the resources
24 necessary to properly set up and manage this
25 program early on, and so we're still playing

1 catch-up on that.

2 The chart on the left-hand side has to do
3 with preparing cases, those 7,000 that I just
4 showed you on the previous slide. The chart on
5 the right-hand side has to do with physician
6 determinations, getting the physicians'
7 determinations. The Y axis here goes from zero
8 to 200, so they're on the same scale, so you can
9 just let your eye kind of drift across and you
10 can see that we're still preparing cases faster
11 than we're getting them through the physicians
12 panel.

13 But if you look on the left-hand side where
14 we're preparing cases, you can see where we had
15 inserts of resources, courtesy of the Congress,
16 to give this program a boost. And basically in
17 about September, October of '03, a little less
18 than a year ago, we received reprogramming
19 approval from Congress for \$9.7 million, which we
20 were able to add to our budget and we increased
21 production of cases threefold. And I shared this
22 with you before, I think.

23 We just received -- in June received another
24 reprogramming of \$23.3 million. We actually
25 asked for \$33.3 because that's what we needed to

1 do to make our goals, but for several reasons
2 Congress allowed us to have \$23.3 million. And
3 you can see the solid line on the left -- left-
4 hand side of that dotted vertical line is
5 remarkably going up, and then on the right-hand
6 side it's kind of -- they're kind of confused
7 there, but there's a dotted line that goes even
8 higher. This is the metric that will actually
9 get up well above 300 cases per week, probably in
10 the next four to six weeks.

11 Now what happened to get us here? We
12 basically hired about 200 case processing people
13 over the last 12 weeks in Washington, D.C. And -
14 - and the reason that that actually -- that curve
15 takes a little dip right there where it says
16 \$23.3 million received is because we took some
17 people off-line to train the new people, so
18 there's some inefficiencies associated with
19 training the new people and we're starting to
20 shoot back up. And my contractors tell me that
21 they're confident that actually by the end of
22 August they should be over 300 cases per week. I
23 would give them a few more weeks beyond that.

24 On the right-hand side is physician panel
25 determinations, and physician panels have always

1 been a challenge for us because we needed --
2 we've had a hard time getting the resources,
3 getting the physicians or the physician time --
4 the FTE, if you want to call it that --
5 especially when they're working on a part-time
6 basis. We made a couple of changes to the
7 program. I think I mentioned last time I met
8 with you folks, we changed the physicians panel
9 rule to allow a single physician to make a
10 determination. And that single-physician
11 determination is if it's a positive.

12 So the first look at any case is done by a
13 single physician, and if that physician finds in
14 the positive, then that physicians panel review
15 is done and that person will get a positive
16 determination. If that first physician rules in
17 the negative, then it would go to a second and to
18 a third physician, if needed, to make sure that
19 we get the two out of three negative. Or if it
20 got another two positives, then it would turn
21 into a positive determination. That change alone
22 has made a dramatic increase in our physicians
23 panel production, and you can see that shown
24 there on the right-hand side.

25 We estimated that mathematically we would

1 roughly double our production, given no new
2 physicians, and we're coming pretty close to
3 tripling our production with that change. Our
4 physicians give us feedback that hey, now I don't
5 have to coordinate with two other physicians
6 across the country electronically. We have
7 several physicians -- from five to seven every
8 week that are working in Washington full-time,
9 and they're, you know, very, very much more
10 efficient. In fact, we give a lot of the second
11 and third reviews to the physicians that are in
12 Washington because the coordination is much
13 simpler when you're sitting across the table from
14 the person you need to coordinate with. So we're
15 seeing some tremendous increases there.

16 And I'll talk later on, too, about the great
17 job that NIOSH and the American College of
18 Occupational Environmental Medicine have done in
19 recruiting new physicians for this program.

20 This chart is a chart of cases unworked. I
21 can't -- I can't paint it any prettier than that.

22 In September of '02 we had about -- a little
23 over 12,000 cases -- applications for this
24 program, and we had not started working those
25 cases. When I took over this program in -- gee,

1 I forget when it was now -- March '03 I guess it
2 was, that number had actually grown to about
3 13,000. We turned the tide -- I can't quite read
4 that -- turned the tide around October to
5 November of last year and are starting to work
6 those off, and you can see this rapidly
7 approaching zero. And this means that there are
8 still about -- at the time of this chart, about
9 7,000 -- I think the number's actually down to
10 about 5,000 today -- there's about 5,000 cases
11 that have come in -- some of them could have come
12 in last week, some of them could have come in six
13 months ago, but they're cases that basically have
14 not been worked yet. We haven't requested
15 documents from the sites and started that
16 process.

17 We're in the process now, based on the
18 reprogramming, the \$23.3 million that I showed
19 you that we got last June, we're requesting all
20 data on all cases from the sites, and that'll
21 drive this number to zero and move all those
22 cases into a currently-worked part of the
23 process.

24 We have what we call a path forward plan. I
25 think I might have shared this with you last

1 spring when I last met with you. It basically
2 has four elements to it. The bottom line is that
3 this is the plan that's going to get us to
4 reducing the backlog of Part D cases to zero by
5 the end of calendar year 2006. At that point in
6 time we'll be where the Department of Labor is
7 today, and that means working cases as they come
8 in the door, working them as fast as we can to
9 get them back out the door. But to work the
10 backlog off will take us to the year -- into the
11 calendar year 2006.

12 Now that's not 25,000 cases that I have
13 today, but it's about 33,000 because there'll be
14 another 8,000 cases that'll come in over the next
15 couple of years while we're working off the
16 backlog, so that's the total number we're talking
17 about.

18 The four-part plan -- first part is
19 regulation changes, and that's done. Basically
20 it was changing the number of physicians on the
21 panels from three to one, which I've already
22 talked about, and also the -- to do multiple
23 reviews for the negative physicians panel
24 determinations.

25 The second element, down here in the lower

1 left-hand corner, is legislation. We need some -
2 - what may look like minor changes made to the
3 legislation, but they'll help us dramatically,
4 one of which is to remove the pay cap on
5 physicians. I've mentioned this before, that
6 we're limited to a certain dollar amount or a
7 certain executive schedule amount that's not
8 reflective of the market value of these
9 physicians' time, and we've had some challenges
10 getting physicians to work for this program at
11 that low pay cap. Also there's some language in
12 the legislation currently that kind of restricts
13 our hiring authority for physicians, and so we
14 need some changes there to expand that hiring
15 authority.

16 There's also a requirement that we have an
17 MOU, a memorandum of understanding, with every
18 state before we process applications in those
19 states, and that -- it's kind of an artifact of
20 the program. At one time we thought we were
21 going to actually do evaluation for every state's
22 claims, and at that point in time we would need
23 to have the agreement from the state to do that.

24 The program is not designed that way now, and
25 hasn't been run that way for two or three years

1 since our rule came out, so the MOU is really
2 unnecessary. And we've got a couple of states
3 that are a little bit reluctant to enter into the
4 MOU with us because they're not sure of their
5 liabilities. And so if we remove that
6 requirement, I can -- I can commence processing
7 claims in those -- those states.

8 The third element is budget. I mentioned
9 it's all about resources. It's about DOE's late
10 start identifying the resources, but it's about
11 the challenge -- the uphill challenge that we've
12 had in the last 18 months getting the resources
13 agreed to, I guess I'll say, by Congress. The
14 reprogrammings we did this past year were all
15 moving money inside the Department of Energy from
16 one type of an account to another type of
17 account, but you still have to have Congress's
18 approval to do that, and there's a lot of steps
19 you have to go through to make that happen. It's
20 been very slow in coming. Not blaming Congress
21 at all, it's just a very detailed bureaucratic
22 process. We needed in '04 \$33.3 million to
23 accomplish what we wanted to accomplish, and
24 we've only gotten \$23.3 in that last
25 reprogramming, so I'm still \$10 million short.

1 We have to do a little bit of quick dancing to
2 figure out how to catch up that in later years,
3 in '05 or '06, but we're still holding to our
4 commitment to process all backlog claims by the
5 end of calendar year 2006.

6 Our '05 budget that we've requested, the
7 President's budget that's on the -- it's in
8 Congress now requests a budget of \$43 million for
9 FY '05. And with that budget we'll have
10 sufficient funds to continue this -- this path
11 forward plan.

12 The fourth and final element in the lower
13 right-hand corner, process changes, many of which
14 have already been implemented. We continue to
15 look for opportunities to optimize and be more
16 efficient in our processes. We've brought in
17 outside reviewers. Others have brought in
18 outside reviewers for us, but we learned from
19 those, such as the GAO reports. But -- so we've
20 made those -- those increases in production.
21 We're looking to produce what we call a tiger
22 team to do a top to bottom scrub of the program
23 here in the near future, something that we really
24 ought to do probably about once a year, look for
25 opportunities to make changes. We reprioritized

1 claims. I think I probably touched on this the
2 last time I met with you, but basically to put
3 living applicants before survivor applicants
4 because living applicants get the greatest
5 immediate benefit from the Workers Compensation
6 program. And then we also have reconstituted the
7 advisory committee, although that committee
8 probably will not have its first meeting until
9 after some of the uncertainty of the fall
10 Congressional schedules clear, so the advisory
11 committee will probably meet in October or
12 November time frame.

13 This is just simply a chart to show you how
14 we'll work off the backlog, and you know -- as
15 you recall, I mentioned about 33,000 applications
16 will be the end number. This is how those
17 applications get worked off. Basically a small
18 number in July '04 -- well, I say a small number
19 but we've got about 3,000 under our belt now and
20 we'll work them off on that schedule. This
21 requires us to process somewhere between 300 and
22 350 applications per week between now and the end
23 of calendar year 2003 -- 2006.

24 Switching gears for a moment, there was some
25 discussion earlier about the support that DOE

1 provides for NIOSH and radiation dose
2 information. We do track that and -- and NIOSH
3 tracks it very closely, and actually this is
4 their data that they provide to us. We take
5 great pride that we have much improved over --
6 from a year to two years ago. One percent is
7 still one percent that we're not getting done
8 within the 60-day time period that we agreed to
9 provide them data, and we continue to -- to
10 attack those. And I think there's been
11 sufficient discussion earlier today on some of
12 the reasons for those differences, but they have
13 to do with database. In some cases we can't find
14 the data and so people are still looking for it,
15 when at some point they may need to just give up
16 and say we can't find the data on this
17 individual. And then there's a couple of cases
18 where we're still waiting for records to be -- to
19 be found or retrieved from archives to provide
20 that -- that data.

21 I talked about additional physicians. NIOSH
22 has provided DOE with a total of 250 physician
23 panel nominees -- and the number may be plus or
24 minus. I apologize to NIOSH if I don't have the
25 number exact today. About 190 of those are

1 actively working. The other 50 to 60, for
2 various reasons, are not working. In some cases
3 it could be the pay, but in other cases they're
4 just busy with their own personal agendas right
5 now and so they've asked not to review cases.
6 Some never started. There's just different
7 reasons, which we try to deal with and increase
8 that number.

9 We did just receive 73, 77 -- something in
10 the seventies -- new physicians from NIOSH just
11 in the past few weeks that are a result of new
12 recruiting activities through ACOM, and I think
13 that's really working out well. And I understand
14 that NIOSH has another 20 potential appointees
15 that they're reviewing right now at NIOSH, so the
16 numbers are getting up there. And also I'm happy
17 to say that a significant number of these new
18 physician nominees are interested in working full
19 time, and boy, do we really get out bang for the
20 buck out of the full time physicians, more than
21 having to mail the stuff back and forth across
22 the country.

23 It's all about money and compensation. And
24 although the DOE is not -- does not pay claims
25 and the DOE is not in control of how claims are

1 necessarily paid, except that we can order our
2 contractors not to contest them, we do track the
3 money. And this is where the claims actually sit
4 today. These are not large numbers, so we've
5 basically completed our work on 7,000 cases.
6 About 3,000 are complete in the program. These
7 are not large numbers, but the pipe is full of
8 product and it's just starting to come out the
9 downstream into the pipeline, if you will forgive
10 me for using that analogy -- 378 people as of
11 this date, which was July 31st, have received
12 positive determinations from our program. That's
13 over 400 now, but it was 378 then, and at the
14 time this snapshot was taken, 87 people had
15 applied for Workers Compensation. And we -- we
16 actually -- when people get a positive, we call
17 them up after they get the letter, explain to
18 them what the letter said, ask them if they
19 understand how to apply for state Workers
20 Compensation. In many cases it's go back to your
21 employer and -- and file a claim with your former
22 employer, and we walk them through those
23 processes. Of the 87 that have applied, 31 at
24 the date of this slide had actually received some
25 compensation, either medical or a settlement

1 payment.

2 We are concerned and we will continue to be
3 concerned and continue to work the gap between
4 the 378 and 87. Some of that's time lag, but
5 some of it is people don't want to apply for Work
6 Comp. Sometimes they're exhausted from the
7 process, and that's not good and we need to get
8 them beyond that. In other cases, they -- they
9 have knowledge that there's not much benefit
10 there for them because either they weren't out a
11 lot of medical expenses or they're survivors that
12 have reached majority age that won't see a lot of
13 benefit from the program. So there's -- there's
14 reasons for that gap, but we continue to study
15 that because we want to encourage as many people
16 as we can to apply for -- for state Workers
17 Compensation.

18 This is the dollar amount, and I wish I had a
19 little more granularity on this for you. I can -
20 - I can kind of talk you through a little bit of
21 it, but at Oak Ridge we've paid out \$415,000 and
22 as -- I'm just remembering from my memory, I
23 think that's about a dozen applicants. Pantex,
24 \$895 -- I'm going to assume that's one or two and
25 it's probably small medical payments. At

1 Savannah River Site, \$161,000, and I think that
2 was like less than five applicants. I think
3 there was one case in there that was up around
4 \$100,000. At Hanford, \$62,000, I think that
5 says. I just don't remember the numbers for
6 Hanford, but I'm thinking it's low -- low teens,
7 so these must be low awards. And then Rocky
8 Flats, \$62,000, and as I recall for Rocky Flats,
9 I think that's four applicants and it's medical
10 payments for Rocky Flats.

11 We hope this chart gets big quickly, and
12 we'll continue to -- to track that. So we've
13 paid out thus far over about \$703,000 in -- in
14 claims. And also we have about another \$750,000
15 in reserves for future medical costs, so thus far
16 the liability for these 31 applicants is up
17 around \$1.5 million.

18 There's always questions about locally here
19 at INEL (sic), what are the numbers here. Total
20 cases we've received here is a little less than
21 1,000 cases for INEL. We've completed 139 of
22 those; 29 of those were positives. If we go back
23 to the chart for Work Comp payments, you saw no
24 Work Comp payments for Idaho -- for the Idaho
25 Engineering Laboratory, and as best we can tell

1 thus far from our communication with applicants,
2 none of our positive applicants here have yet
3 applied for Work -- Workers Compensation as a
4 result of the EEOICPA program. We do think we
5 have information, and we're still clarifying
6 that, that about three or four of the people that
7 got positives, three or four of these 29, had
8 received Workers Compensation payments prior to
9 the existence of this program, so in addition to
10 having already received compensation, they may
11 have applied for the program just to get the
12 paper and the physicians panel determination that
13 -- that clearly shows that the DOE work was
14 responsible for their illness.

15
16 We have a total 180 cases for Idaho that are
17 currently in the physicians panel process, so
18 we'll be seeing those come out in the next 30, 60
19 days kind of time frame; 87 cases are still
20 awaiting development, and we expect those to be
21 pushed to zero in the next month, month and a
22 half.

23 With that, I'll be happy to answer any
24 questions.

25 DR. ZIEMER: Tom, do you see many cases where

1 individuals start out in the Subpart D program
2 and clearly should be in -- into the dose
3 reconstruction, NIOSH, that you kick the other
4 way, and vice versa? How -- how much is there
5 back and forth between --

6
7 MR. ROLLOW: We've done some data matches
8 with the Department of Labor over time, and I
9 think our data matches are somewhere in the 90 to
10 95 percent -- people in our program are also in
11 the Part B program, so there's about a 90 to 95
12 percent data match.

13 Generally the resource centers are where most
14 of them do the applications, and the resource
15 centers serve both the Department of Labor Part
16 B, as well as the Department of Energy Part D,
17 and so the people in the resource center counsel
18 them -- what kind of illness do you have, where
19 did you work? Oh, gee, you might want to apply
20 for this other program, also. So I think we're
21 getting a lot of good front end service on the
22 application process to take care of that. But
23 yes, we do see on occasion where there's an
24 individual that just is in the wrong program.

25 Of course, my prog-- everyone -- almost

1 everyone that's eligible for the Labor program is
2 eligible for my program, but not vice versa. So
3 we see a lot of referrals come over from the
4 Department of Labor.

5 DR. ZIEMER: Roy?

6 DR. DEHART: Tom, last time I raised a
7 concern about the radiation issue, that
8 physicians who are reviewing these cases in Part
9 D may not have the background, and yet have a
10 case that is a cancer case with radiation
11 implications. What are we doing to assure that
12 the physicians are aware of this NIOSH program,
13 that they know how to interpret the data that's
14 coming through NIOSH? Not every case that I've
15 seen has been reviewed because the applicant has
16 chosen to move forward with Worker Comp rather
17 than wait till there has been a dose
18 reconstruction.

19 MR. ROLLOW: All right. Several issues
20 there. I'll take them one at a time. First of
21 all, originally in this program -- let me back
22 up.

23 A subset of applicants for this program are
24 also getting dose reconstructions done at NIOSH
25 for radiogenic cancers. And originally in this

1 program those cases were sent forward to the
2 physicians panels for the physicians to determine
3 if they felt that their injury -- the applicant's
4 injury on this was caused by their work.

5 Obviously it would have been easier for the
6 physicians, if they had the information from the
7 NIOSH dose reconstruction, to make that decision.

8 We changed that policy about six or nine months
9 ago. Some of those cases still did go through
10 the program. In some cases -- a few cases,
11 people got a positive determination from our
12 program for radiogenic cancer and they had not
13 yet gotten a determination from the Department of
14 Labor. In some cases they would get a negative
15 from our program, and what we do there is if the
16 dose reconstruction comes through and if the
17 Department of Labor gives them the equivalent of
18 a positive for that program, they would be
19 reconsidered in our program. So we're trying to
20 be applicant-friendly there.

21 The second part of your question, though,
22 refers more directly to the physicians. And the
23 physicians now -- a larger population of
24 physicians who are not necessarily experienced at
25 radiogenic cancers, and we are continuously

1 trying to provide resources and information to
2 those physicians to satisfy their need to make
3 these decisions. And the most recent request,
4 which we've actually been working on for a couple
5 of months now, it's not fully well-resolved or
6 developed, is to provide them some training in
7 the details of the NIOSH dose reconstruction --
8 and I assume that's what you're referring to. We
9 are working with NIOSH to try to figure out what
10 we can do in that area to provide them more
11 information on those NIOSH dose reconstructions,
12 and it'll probably be in the form of either
13 national conference calls or televideo, VCR tapes
14 or that kind of information.

15 DR. ZIEMER: I didn't see the order these
16 came up, so let's just go around the table.
17 Rich, and then Mike and Jim.

18 MR. ESPINOSA: Two questions. Under the MOU
19 and the states that are reluctant to get under
20 this -- basically I'm kind of concerned on what
21 are the specifics, and also applicants apply for
22 Workers Comp. Does the state statute of
23 limitations have anything to do with the big
24 change in numbers? I mean there's 376 and only
25 87 that have applied?

1 MR. ROLLOW: Right, those are both very good
2 questions. First of all, as far as the MOU goes,
3 let me just give you an illustrative example that
4 worked out well. The State of Florida we did not
5 have an MOU with until about two months ago, and
6 I think our issue there was just a lack of
7 communication and understanding with the State of
8 Florida as to what their liability would be with
9 our program. Generally our program -- I want to
10 say pays its own way through the State Comp
11 system, because most, if not all -- well, most --
12 99 percent of DOE contractors do what's called
13 retrospective insurance. And that means that at
14 the end of the year they end up paying --
15 reimbursing their insurance companies for the
16 cost of a Work Comp claim and the U.S. Department
17 of Energy ends up reimbursing the contractors for
18 the cost of that claim, so the money actually
19 comes out of the DOE's pocket. And so the states
20 in many cases have little to worry about where
21 there is what's called a so-called willing payer.

22 Another state where there's a challenge is in
23 Missouri. There's some questions about the
24 Mallinckrodt facility as to whether there's a
25 willing payer or will be a willing payer at the

1 Mallinckrodt facility in Missouri, and so the
2 State of Missouri is a little bit reluctant to
3 sign an MOU and -- and -- and sign on to some new
4 liability that they're a little bit unclear of,
5 and so that's -- that's the issue in the state.

6 Your other question was...

7 MR. ESPINOSA: Applicants apply for Workers
8 Comp. There's -- there's...

9 UNIDENTIFIED: Statute of limitations.

10 DR. ZIEMER: Statute of limitations.

11 MR. ESPINOSA: Statute of limitations.

12 MR. ROLLOW: Oh, statute of limitations. We
13 are not -- we're -- when we order our contractors
14 not to contest a claim we're also telling them
15 not to raise administrative defenses, which the
16 statute of limitation is. In most states they'll
17 leave that up to the -- and I'm going to -- I'm
18 going to define this wrong, and you -- some of
19 you are experts in workmen's compensation, but in
20 most states the states would leave that up to the
21 employer and the employee to resolve a settlement
22 on a claim. And so we're -- statute of
23 limitations does not enter into the case.

24 In some states, however -- for example, I'll
25 use Ohio as an example -- where there's a state

1 fund so that the State of Ohio is actually the
2 insurance company, they're required by law to
3 raise statute of limitation defenses in these
4 claims. And so we may have some problems in
5 Ohio. The first few claims are just starting to
6 hit Ohio soon, working very closely with Ohio to
7 figure out creative ways to not only help them
8 get around their statute of limitations that
9 they're required -- the defenses that they're
10 required to raise, but also look for creative
11 ways that we can reimburse the state, and we're
12 getting close on that.

13 We're getting close in two ways. One way is
14 that there's some legal things we can do in our
15 insurance arrangements in the state of Ohio. And
16 secondly, there may be some legislative fixes
17 that might be made on the Hill, in the Congress,
18 on that subject.

19
20 MR. ESPINOSA: How is that working out with
21 the -- well, say contractors -- site contractors
22 that are not self-insured?

23 MR. ROLLOW: Right now, as far as I know, for
24 the claims that have been filed in the DOE system
25 where we have a contractor that we can make a do-

1 not-contest order, I know of no contractors that
2 have raised a statute of limitations
3 administrative defense. And if we find those,
4 we'll go work those on an individual basis.
5 We'll go remove them, basically.

6 MR. GIBSON: You mentioned Ohio, and I
7 noticed on your slide nine the cases that have
8 been paid. Have there been any cases at all paid
9 in the state of Ohio?

10 MR. ROLLOW: Ohio -- there sort of have, and
11 let me explain to you how that works. You're
12 probably familiar with the settlement fund for --
13 the Fernald Settlement Fund I think it's called
14 in the State of Ohio -- where there's a program
15 that actually we modeled a lot of our program
16 after. It's where physicians look at illnesses
17 that Fernald workers may have received from their
18 work at the Department of Energy facility in
19 Fernald. And a lot of those claims have -- have
20 received positive findings from the Fernald
21 Workers Settlement Fund, and then have gone
22 forward to the State of Ohio and been paid -- not
23 as a direct result of the EEOICPA program, but
24 those workers may have been paid for the same
25 illnesses that they've applied to our program

1 for. So the State basically has paid that out of
2 the State fund. DOE at this point has not
3 reimbursed that State fund for those payments,
4 and has not yet found a legal way -- we're
5 working with Ohio, on the phone with them twice a
6 week right now, but we have not found a legal way
7 that we can reimburse them for those compensation
8 costs. So I know those claims have been paid. I
9 do not know whether any Portsmouth, Ohio facility
10 or Mound facility claims have actually made it to
11 the State process.

12 MR. GIBSON: So that the Fernald payments
13 were based on a out-of-court settlement from a
14 lawsuit.

15 MR. ROLLOW: Well, no, no, the payments --
16 let me clarify that. The settlement fund pays
17 for the physicians to look at the cases, but does
18 not pay the compensation cost. The State fund
19 pays the compensation cost. So the State of Ohio
20 Workers Comp fund, that \$2 billion fund, that
21 great big insurance fund, if you will, paid the
22 claims, not the settlement fund.

23 MR. GIBSON: But under EEOICPA, there have
24 been no funds -- no claims paid in Ohio.

25 MR. ROLLOW: That's correct. We're working

1 with the State to find a way to get around the
2 state law, basically, in Ohio.

3 MR. GIBSON: So in essence then, there's no
4 willing payer in the state of Ohio.

5 MR. ROLLOW: We're willing, but -- but -- I
6 mean -- this is -- it's kind of a -- a challenge
7 of words here. The Department is willing, but
8 the state law does not have a way to get around
9 it right now. And I think we'll end up with a
10 solution to that soon.

11 MR. GIBSON: Lastly -- and I've brought this
12 up before because of these cases pending and
13 stuff -- does ??? still -- is ??? still resistant
14 to transferring this -- this portion of the
15 program to the Department of Labor so that it --
16 you don't have to work with each state and these
17 people can get their compensation?

18 MR. ROLLOW: Yeah, we're -- of course what
19 you're referring to is the Senate Defense
20 Authorization bill, which has adopted an
21 amendment, I think sponsored by Senator Bunning*,
22 which would transfer the program to the
23 Department of Labor, make some rather dramatic
24 changes to the nature of the program, and also --
25 basically transfer it and make some dramatic

1 changes to it. The opinion -- the position of
2 the Administration -- the Department of Labor,
3 the Department of Energy and the Executive Branch
4 of the government -- is that this would not be a
5 good idea to transfer the program from Department
6 of Energy to the Department of Labor.

7 The reason are several-fold. One is the
8 Department of Energy, as I'm showing you here,
9 has fixed the production problems, so the numbers
10 are coming up in those areas and we have a plan
11 to work off the backlog. Secondly, it's very
12 inefficient to uproot a program from one agency
13 and move it to another agency. And then thirdly,
14 there's some tremendous challenges, complications
15 -- and some of them may not even be workable, the
16 way the legislation is written -- for the
17 Department of Labor to actually run the program,
18 the way the legislation is written. And it's a
19 little more complex than I probably ought to be -
20 - ought to go into with you here today.

21 MR. GIBSON: Well, I -- you know, with all
22 due respect, it just seems to me, with -- you
23 know, \$20, \$30, \$40 million requested next year
24 for this program and \$700,000 put out to workers,
25 it obviously seems like there's some serious

1 impediments with this.

2

3 MR. ROLLOW: And -- and I don't disagree with
4 you about the slow start. I think what we all --
5 do ask you to focus on the fact that the pipeline
6 is full and there's product coming out the tail
7 end of it, and you will see that go up
8 dramatically over the next few months.

9 DR. ZIEMER: Okay. Mark?

10 MR. GRIFFON: Yeah, I'm trying to understand
11 the -- just -- just to get a sense of this
12 production that you described. Your one table,
13 the second slide, versus a couple of the graphs -
14 - I mean if I look at -- if I'm looking at this
15 right, it seems like there's about 25,000 cases
16 overall.

17 MR. ROLLOW: Uh-huh.

18 MR. GRIFFON: And the backlog is around
19 22,000 -- I guess it depends on how you define
20 backlog.

21 MR. ROLLOW: How you define backlog. We're
22 working --

23 MR. GRIFFON: Cases that haven't gone through
24 the physicians panels.

25 MR. ROLLOW: There's 20,000 cases currently

1 being worked -- 5,000 that are not being worked,
2 but 20,000 are currently being worked.

3 MR. GRIFFON: Uh-huh.

4 MR. ROLLOW: Of those 20,000 currently being
5 worked, DOE has finished assembling the case file
6 on 7,000 of those.

7 MR. GRIFFON: Okay.

8 MR. ROLLOW: Has finished assembling the case
9 file, so the case now is sitting either in an
10 applicant's mailbox waiting to be reviewed by the
11 applicant, or it's sitting at a physicians panel
12 or waiting to go to a physicians panel, or it's
13 complete and done.

14 MR. GRIFFON: Okay. And -- and there's --
15 and if I'm looking at this right, there's been
16 about 1,100 that have gone through the physicians
17 panels?

18 MR. ROLLOW: That's correct.

19 MR. GRIFFON: Because I -- I'm trying to
20 interpret this total cases completed. It seems
21 to me that -- that set of ineligible applicants
22 over -- I'm sorry, I need a magnifying glass --

23 MR. ROLLOW: Yeah.

24 MR. GRIFFON: -- or cases withdrawn by
25 applicant --

1 MR. ROLLOW: See if I can --

2 MR. GRIFFON: -- if those two categories -- I
3 think those are kind of exhausted right at the
4 outset, I would think. In other words, that --
5 that you're -- you're rolling them into the total
6 cases completed --

7 MR. ROLLOW: Right, but -- but --

8 MR. GRIFFON: -- but I think they don't go
9 through the physicians panel at all.

10 MR. ROLLOW: That's right, but -- but --

11 MR. GRIFFON: That's a one-time hit, I
12 believe. Right?

13 MR. ROLLOW: But not unlike the Department of
14 Labor program. I mean ineligibility, once that's
15 determined, that is a completed case.

16 MR. GRIFFON: Right, I don't dispute --

17 MR. ROLLOW: Obviously it makes more sense
18 for us to try to disposition those at the front
19 end of the process, and we do try to pick up as
20 many of those as we can when they first come in
21 the door. In fact, what we've actually done is
22 we've rolled back to the resource centers where
23 we take applications, and we're trying to do a
24 little better job there of figuring out if people
25 really are eligible for the program before they

1 apply -- make sure they worked during a covered
2 time period, worked at a covered DOE facility,
3 and that they're actually ill -- or have an
4 illness.

5 MR. GRIFFON: I guess -- I guess what I'm
6 trying to -- to understand is that those seem
7 like one-time hits out of the 25,000.

8 MR. ROLLOW: Yes, absolutely.

9 MR. GRIFFON: And when you roll them into
10 that percentage completed by the -- com-- you
11 know, already complete process --

12 MR. ROLLOW: Uh-huh.

13 MR. GRIFFON: -- it looks a little inflated
14 there at 12 percent. Really 1,100 have gone
15 through the physicians panel. So I'm trying to
16 get a sense of how -- it looks like you're
17 scaling up significantly on the physicians
18 panels, and I understand you've hired a lot more
19 physicians, so that --

20 MR. ROLLOW: Uh-huh.

21 MR. GRIFFON: But if I look at the -- one of
22 the graphs right, your sixth overhead there, it
23 looks like you're going to be up to around 800
24 cases per month --

25 MR. ROLLOW: Absolutely.

1 MR. GRIFFON: -- going through the physicians
2 panels, and that's a realistic estimate you've
3 looked at?

4 MR. ROLLOW: Yeah, we -- we -- our -- our
5 plan with -- that we -- that we put in front of
6 Congress for our last funding committed to doing
7 300 -- 300 cases per week -- actually 15,000
8 cases in a year, which averages 300 a week; 200
9 cases per week starting -- for the first year up
10 to the panels, and only 100 cases per week
11 through the panel. And that first year started
12 last June and would end next June. We actually
13 expect to be up to 200 cases per week totally
14 completed, out of the panels, probably in the
15 November time frame, because we're getting
16 sufficient numbers of physicians and physician
17 hours right now. So we'll -- we'll greatly
18 exceed that goal.

19 MR. GRIFFON: And you said you've hired 200
20 or so other case processors?

21 MR. ROLLOW: Right.

22 MR. GRIFFON: Are those -- what -- what kind
23 of entities* are those?

24 MR. ROLLOW: Well, a case processing team
25 consists of a medical person of some type,

1 generally a nurse, and then that nurse is
2 supported by technicians and administrative
3 helpers that get the information together, work
4 with the sites to retrieve the information,
5 assemble it according to certain protocols, and
6 then the nurse -- or the nurse equivalent; I
7 think they're all nurses in our program --
8 actually have the final say on the case before it
9 moves forward to the final part of the process.

10 MR. GRIFFON: Are there any industrial
11 hygienists or health physicists in that team of
12 200?

13 MR. ROLLOW: I have several on my staff, the
14 DOE staff. Most of our -- a large number of our
15 nurses are -- have occupational medical
16 experience, but not necessarily industrial
17 hygienists. So I would have to say probably not.

18 MR. GRIFFON: Okay. And I have one other
19 question, but this is switching gears completely.

20 It's -- out of your budget I'm curious how much
21 -- I think it was either in NIOSH's presentation
22 or in this one there was a discussion of when
23 NIOSH requests information of -- from DOE --

24 MR. ROLLOW: Uh-huh.

25 MR. GRIFFON: -- I think you -- does that go

1 through your office? Am I correct about that?

2 MR. ROLLOW: Well, it -- it --

3 MR. GRIFFON: Data (Inaudible) --

4 MR. ROLLOW: -- my office facilitates it, but
5 we've arranged it so they communicate directly
6 with the sites, so we've cut out the middle man.

7 MR. GRIFFON: Okay. But does that come out
8 of your budget, the --

9 MR. ROLLOW: Yes, I --

10 MR. GRIFFON: -- cost of that down at the
11 site level?

12 MR. ROLLOW: -- I pay for that service,
13 that's correct.

14 MR. GRIFFON: And that -- this is -- this
15 will come up maybe later in our discussions, but
16 does that also cover the cost of our auditor --
17 audit contractor requesting records?

18 MR. ROLLOW: I don't know -- I don't think
19 NIOSH is providing any additional funding to our
20 sites to support your auditor, so I'd have to say
21 that right now either the auditor's -- servicing
22 the auditor at our sites either comes out of my
23 funding or it's coming out of the sites'
24 overhead.

25 MR. GRIFFON: Has that come up yet to your

1 office, to --

2 MR. ROLLOW: Not to me.

3 MR. GRIFFON: -- your attention, to --

4 MR. ROLLOW: Not to me.

5 MR. GRIFFON: Hasn't come up as an issue yet.

6 MR. ROLLOW: I think it's probably better
7 addressed by NIOSH and -- and by the contractor.

8 I have -- my people have had some discussions, I
9 think at Savannah River Site, to make sure the
10 doors are open to the auditor at the Savannah
11 River Site. I don't know any of the details. I
12 just know we were involved in some discussions on
13 that subject.

14 MR. GRIFFON: Well, I -- I think we -- I
15 think we need to get this on the -- the scope of
16 our discussions somewhere, especially why Tom is
17 here, maybe, because my understanding at a
18 previous meeting was that there would be no
19 problems as far as access for the --

20 MR. ROLLOW: Absolutely.

21 MR. GRIFFON: -- for the auditor coming
22 directly --

23 MR. ROLLOW: Our MOU, which is signed by the
24 Deputy Secretary of HHS and the Deputy Secretary
25 of DOE, provides for full and open access to

1 NIOSH and anybody that's supporting NIOSH. And
2 so my -- you know, our courtesy or whatever you
3 want to call it goes to Larry Elliott and to his
4 organization. How he turns around and -- and
5 extends that to contractors that support the
6 Board or that support him is up to him. We just
7 sent a letter out to the field -- to all field
8 offices and copied Mr. Elliott on that letter,
9 that reflected the letter I think that you folks
10 actually sent to the Secretary of Energy and --
11 and reiterated that to our field offices, and
12 said if you have any question on that subject to
13 call Larry Elliott, because NIOSH has to actually
14 open the door with their key, and if there's any
15 DOE problems, to call somebody in my office.

16 DR. ZIEMER: I might insert that this Board
17 sent a letter to the Secretary of HHS, who in
18 turn made contact with the Secretary of DOE and -
19 - and based on that letter, which Tom provided to
20 his field contacts very recently to underline the
21 need for access, specifically by the Board's
22 contractor, so --

23 MR. GRIFFON: I guess I'm -- I'm getting back
24 to the point where I believe -- I don't want to
25 put words in Tony's mouth, but I think he raised

1 this at one meeting that a question at the site
2 level of an unfunded mandate sort of, that they
3 get these requests all the time from various
4 researchers and everybody, and they want to know
5 who do I bill to. And it is -- I was just
6 wondering --

7 MR. ROLLOW: Well, I think we have to take
8 those --

9 MR. GRIFFON: It's your impression that
10 that's also --

11 MR. ROLLOW: Well, I can't --

12 MR. GRIFFON: -- access and -- and costs are
13 covered.

14 MR. ROLLOW: Yeah, I right now fund the
15 Department of Labor employment verifications, and
16 I also fund NIOSH radiation dose -- requests for
17 radiation dose information. I can fund a little
18 bit of access to your contractor. But if it
19 becomes a larger burden, that may be something
20 that NIOSH and the Department of Labor may have
21 to take up with us to work out some kind of
22 solution. Generally overhead at the sites can
23 accommodate some of this. It just depends on how
24 much time it takes to service the request, and I
25 just can't speak to that 'cause I'm not sure what

1 your contractor's doing.

2 DR. ZIEMER: Mike, and then Tony.

3 MR. GIBSON: You mentioned that your office
4 funds the records search and all that.

5 MR. ROLLOW: Uh-huh.

6 MR. GIBSON: Does the local DOE office have
7 the right, once the funding gets to that level,
8 to do something else with it and take the monies
9 out of the contractor's operating fund?

10 MR. ROLLOW: I don't know whether they have
11 the right, but they haven't done it yet and we
12 watch it pretty closely.

13 MR. GIBSON: Watch the Ohio sites --

14 MR. ROLLOW: We --

15 MR. GIBSON: -- (Inaudible) in particular?

16 MR. ROLLOW: Yes. The Ohio sites don't get a
17 lot of money from us, but yes, we watch it very
18 closely.

19 MR. GIBSON: And secondly, just as a comment
20 --

21 MR. ROLLOW: If you know something I don't
22 know, send me an e-mail tomorrow and let me know,
23 'cause we're always chasing down the dollars.

24 MR. GIBSON: And then secondly, there are
25 some DOE contractors that are vigorously fighting

1 Workers Compensation claims to this day.

2 MR. ROLLOW: Okay.

3 MR. GIBSON: They are -- they are putting
4 employees who get injured on the job under the
5 sickness and accident plan and fight -- if they
6 choose -- if the worker chooses to go Workers
7 Comp, they're -- they're appealing it all the way
8 to the top.

9 MR. ROLLOW: If they involve EEOICPA claims,
10 which is -- I mean I hate to put blinders on, but
11 of course my area is EEOICPA. But if they
12 involve people who have positive determinations
13 from the EEOICPA process, I'd be very interested
14 in -- in the details of those and we'll go after
15 them.

16 DR. ZIEMER: Thank you. Tony?

17 DR. ANDRADE: Yes, I just had a comment. I
18 just wanted to remind the Board that during
19 whatever meeting it was that I did mention that
20 researchers or even our contractor going into DOE
21 contractor's site would be considered an unfunded
22 mandate. My statement was the basis for -- or
23 was actually to be used as the basis for asking
24 the Department of Energy to support that.

25 Now that the letter has gone out and I know

1 that it has certainly arrived at my site and I'm
2 sure at all the other contractor sites -- active
3 contractor sites -- the order is given, and in
4 many cases overhead is used like for record
5 centers to provide services and support the
6 contractors. And then sometimes it's even
7 programmatic funds that come out of say radiation
8 protection programs to provide information
9 directly to the subcontractor. And so it is a
10 combination of dollars, but the contractors have
11 been ordered to do, so therefore they will.

12 DR. ZIEMER: Thank you, Tony. Roy?

13 DR. DEHART: Tom, you alluded to the fact
14 that there are some differences here on
15 reimbursement. For the benefit of the Board,
16 would you again give a little explanation to why
17 the death of the claimant and the compensation
18 thereof may be entirely different with the Worker
19 Comp versus what we are seeing from cancer? I'm
20 primarily talking about the siblings, the
21 children.

22 MR. ROLLOW: Okay. Now are you talking the
23 difference between Part B and Part D?

24 DR. DEHART: Yes.

25 MR. ROLLOW: Okay. Well, Part B obviously is

1 a -- is a set -- set amount, \$150,000. For a
2 survivor who has made an application to this
3 program because say a parent may have succumbed
4 to an illness caused by their work at the
5 Department of Energy, if they have reached
6 majority age -- in other words, over 21 or
7 whatever majority age is in that state, and I'm
8 not real well-versed on this, so there's probably
9 people in this room that are a lot more
10 knowledgeable on Workers Comp than I am. But if
11 they've reached majority age say at the time that
12 that person had expired, they were not dependent
13 perhaps on the income from that worker, there
14 would -- there may be very little compensation
15 due to them, say other than maybe a burial
16 payment or something of that sort. So in some
17 states we might see an award -- several thousand
18 dollars, basically just a burial payment to that
19 -- to that person. In other cases, if the worker
20 succumbed to an illness and died during their
21 working career and it's a -- it's a widow that
22 was dependent upon that worker, they're making an
23 application to the program, there may be lost
24 wages, there may be a large death benefit in the
25 six figures. Is that the explanation you're

1 looking for?

2 DR. DEHART: One of the points is the
3 minority issue of the children, which we don't
4 have to deal with with the cancer --

5 MR. ROLLOW: Right.

6 DR. DEHART: -- issue. And if -- and we've
7 all heard comments about the time criticality in
8 dealing with the cancer issue. It's even more of
9 a critical issue in dealing with the Worker
10 Compensation.

11 MR. ROLLOW: It -- it can be, although
12 generally most of our -- a large percentage of
13 our applications are survivor applications, and -
14 - and that person expired even before the program
15 was passed into law, many cases.

16 DR. ZIEMER: Tom, could you address very
17 briefly sort of the quality control issue on
18 physicians? Now I recognize that, maybe with the
19 exception of the physicians who are on this
20 Board, there are some whose judgment may not be
21 faultless. And how do you -- when you have a
22 one-person decision point, how do you assure --
23 well, let me ask it this way. Do you go back and
24 say is physician A always judging for the
25 claimant or against the claimant; is there a

1 pattern that suggests other than objective
2 evaluation? Or do you see the things -- do you
3 send out an application, a duplicate one, to
4 several and cross-calibrate them; or is there
5 some kind of quality control on those judgments?

6 MR. ROLLOW: You're really putting me in the
7 hot seat here. We do not score our physicians.
8 We do not try to pre-judge or to judge, based on
9 their performance, which way they're going to go.

10 We do try to educate and communicate to them if
11 we see them constantly leaning in one direction
12 or the other. The single physician case is going
13 to always be applicant-friendly, because if a
14 single physician leans one way or another, the
15 only way it can -- it can do -- the only thing it
16 can do is help the applicant, because if they're
17 always negative, there are two other physicians
18 that also would have to -- well, one other
19 physician would have to be -- have a negative on
20 that same case, and that's why we retain the
21 review from two or more physicians to get a
22 negative. But we --

23 DR. ZIEMER: I'm more concerned about the
24 luck of the draw for someone who's always
25 positive.

1 MR. ROLLOW: Well, there may be some of
2 those. What we do is we try to look for those.
3 We do review every single case in detail, both by
4 a panel of physicians that -- that were -- excuse
5 me, not a panel, bad terminology -- by physicians
6 that are under my employment, and I also have a
7 medical director, Dr. Mike Mentopali*, and we
8 review 100 percent of all the decisions. And if
9 we see things skewed, we will go back and work
10 with that physician to -- to clarify either
11 policy in the program, to provide them additional
12 technical information, medical information to
13 help them make better judgments.

14 On the other hand, the process is set up by
15 law for an arm's-length relationship between DOE
16 and the physicians. And I have to be very, very
17 respectful of that distance. And as a result
18 there may be a program that we might want to run
19 here that has more consistent results, but that
20 won't end up with that consistency because of
21 that arm's-length relationship.

22 DR. ZIEMER: Any further questions?

23 (No responses)

24 DR. ZIEMER: Thank you very much, Tom. We
25 appreciate the update on that part of the

1 program.

2 It's now 12:15. We'll -- we'll shoot for --
3 let's say 1:30, if possible. I'm not sure how
4 convenient lunch places are here. Do we have a
5 list or anything of -- there's not much choice is
6 what I'm hearing. Okay. Shoot for 1:30. Thank
7 you. We're in recess.

8 (Whereupon, a luncheon recess was taken.)

9 DR. ZIEMER: Okay, we're going to go ahead
10 and reconvene. Our regular Designated Federal
11 Official is not present, and we have to have one,
12 so the Acting Designated Federal Official is Jim
13 Neton, and when Larry arrives they will play
14 musical chairs and trade.

15 PRIVACY ACT AND FACCA REQUIREMENTS

16 But anyway, we're going to begin the
17 afternoon session. Liz Homoki-Titus is going to
18 in a sense update us on Privacy Act issues and
19 bring us up to speed on anything new in --

20 MS. HOMOKI-TITUS: Well, I think I am.

21 DR. ZIEMER: Yes, we think Liz is going to do
22 that. So Liz?

23 MS. HOMOKI-TITUS: Okay. One piece of news
24 that I want to share with you all, and you've
25 probably noticed that David Naimon is no longer

1 with us. He has been promoted to the Associate
2 Deputy General Counsel, so he'll no longer be
3 attending Board meetings or working with this
4 program, which has left me as the acting team
5 lead, and at some point in the future you may see
6 a new team lead who will be introduced to you, et
7 cetera. But for right now, if you have any legal
8 questions, any questions about the Privacy Act or
9 anything else, you're still free to contact our
10 office at the same number but you'll probably be
11 dealing with me instead of David Naimon.

12 As I indicated to you at the last meeting, I
13 wanted to go a little more in depth on the
14 requirements of the Privacy Act. Now that you
15 all are going to start reviewing individual dose
16 reconstructions through your work groups and the
17 subcommittee, and also as a committee, as well as
18 beginning work on SEC petitions, this is once
19 again very, very important for you to consider
20 and remember.

21 What is the Privacy Act? It is Federal
22 withholding statute, which means -- withholding
23 means the Act prohibits the disclosure to any
24 third party information about a person without
25 that person's written permission. If you all

1 receive a request for a disclosure of a Privacy
2 Act record, which is just basically anything that
3 deals with an individual, please have that person
4 contact OCAS, and please let OCAS know that
5 you've received that request so that they can be
6 aware of it and take care of it properly.

7 HHS also has their own Privacy Act policy,
8 and it is the policy of the Department to protect
9 Privacy Act information to the fullest extent
10 possible. That means that we do allow the
11 disclosure of records -- i.e., you all will be
12 receiving full dose reconstruction reports -- for
13 employees of the Department to do their jobs.
14 But we do not disclose records to other people
15 unless it's proper under Freedom of Information
16 Act or we have received a proper Privacy Act
17 release.

18 I do want to remind you that there are civil
19 and criminal penalties that you will be held
20 personally responsible for if you are found to
21 have wilfully violated the Privacy Act. And
22 please be aware that the criminal penalties can
23 be up to \$5,000, which you would be personally
24 responsible to pay if you were found guilty.

25 There are some permitted disclosures with the

1 Privacy Act. These are disclosures that would be
2 handled by the Department, not handled by you
3 personally. If the government has a record that
4 pertains to an individual, they have a stat--
5 they have the right to have that record. And
6 then there's some other special interests that
7 have access to records, especially at the
8 Department of Health and Human Services where we
9 have medical records.

10 And of course there are prohibited
11 disclosures of the Privacy Act-protected
12 materials. And basically you cannot disclose
13 Privacy Act-protected materials to anyone unless
14 the Department of Health and Human Services has
15 received a written release for the release of
16 that information to that particular person. For
17 example, this includes dis-- precludes
18 disclosures without written permission to family
19 members, medical personnel and members of
20 Congress, with certain exceptions that are
21 statutorily set.

22 You've probably seen these before, but I'll
23 run through them for you one more time. They're
24 Privacy Act rules for special government
25 employees, and I'll remind you again that each of

1 you is a special government employee who is an
2 employee of the Department of Health and Human
3 Services each time you're working on Board
4 activities. So generally, avoid discussing or
5 disclosing the merits of individual claims and
6 SEC petitions. Stick to giving out public
7 information. The public does view you as
8 representatives of the Department of Health and
9 Human Services because you are in the public eye.

10 And you are allowed to share publicly-available
11 information, but you can't share information
12 specific to a person that you may have learned in
13 their dose reconstruction report or in an SEC
14 petition. When y'all are having dinner and stuff
15 like that, avoid speculating about the identity
16 of claimants, SEC petitioners or SEC class
17 members. Avoid speculation about dose
18 reconstruction and SEC issues that the Board may
19 be considering, or that you may know that the
20 Department is considering. Try to avoid
21 predicting Department and Board future actions.
22 You know that you're supposed to avoid assisting
23 with the filing of individual claims, but you may
24 be a fact witness, because we know that a lot of
25 you have worked in this area and you may have

1 friends that -- or coworkers that you worked with
2 for whom you can be a fact witness. And if you
3 have any questions about that or you've been
4 asked to be a fact witness, please feel free to
5 contact OCAS or us to discuss what if any
6 limitations that your Board role may have for
7 you.

8 DR. MELIUS: These aren't all Privacy Act
9 issues, though.

10 MR. GRIFFON: Right.

11 MS. HOMOKI-TITUS: No, some of them aren't.

12 DR. MELIUS: Most of them aren't. I think
13 you need to be clearer about that.

14 MS. HOMOKI-TITUS: Well, the first one's a
15 Privacy Act informa-- is Privacy Act.

16 DR. MELIUS: For SEC petitions?

17 MS. HOMOKI-TITUS: It can be because you've
18 got three individual -- if you have three
19 individual --

20 DR. MELIUS: (Inaudible) --

21 MS. HOMOKI-TITUS: -- petitioners.

22 DR. MELIUS: -- names, but --

23 MS. HOMOKI-TITUS: Right. Public
24 information's not.

25 DR. MELIUS: Yeah, okay. I mean you don't

1 have to go through them all, I just --

2 MS. HOMOKI-TITUS: Okay. As I've mentioned
3 throughout the presentation, there is no reason,
4 as a member of the Advisory Board, that you
5 should be disclosing Privacy Act-protected
6 materials to anyone. You are not an appeals
7 board, so therefore people will not know if
8 you're reviewing their dose reconstruction, so
9 therefore you shouldn't be discussing with
10 anyone, including -- if you're talking to the
11 person whose dose reconstruction you're reviewing
12 -- their information with them.

13 SEC petitions that you all are reviewing
14 should not be discussed outside of the Board
15 meeting. And once again, if you get a request
16 for a disclosure of any type of Privacy Act
17 information, please direct them to OCAS and let
18 OCAS know that you've received that request.

19 Now moving on to the role of the Advisory
20 Board under the Federal Advisory Board Committee
21 Act, which is FACA, you'll hear me refer to it.
22 In 1972 Congress felt that it was important to
23 regulate the role of advisory boards within the
24 Executive Branch. And the law has special
25 emphasis on open meetings, chartering, public

1 involvement and reporting.

2 Congress there was a need to share
3 information that advisory boards were giving to
4 the Executive Branch with Congress and with the
5 public. They also determined that the role of an
6 advisory board should be advisory only.

7 Under the advisory functions of the advisory
8 board, unless there's a Presidential directive or
9 your statute specifically provides for you to do
10 so, then the role of the board is only advisory.

11 For this specific Board, Congress nor the
12 President gave you authority to make
13 determinations on the behalf of the Department of
14 Health and Human Services. You advise the
15 Secretary, and that's your only function.

16 FACA also required there be a charter filed,
17 and it needs to be filed with the head of the
18 agency with whom -- to whom you report, which is
19 the Secretary of Health and Human Services. You
20 all do have a current charter, and you also now
21 have a charter for your subcommittee, which will
22 be important in a few minutes.

23 The law also requires that you have a
24 Designated Federal Official at all of your
25 meetings, so therefore for the Board to have a

1 meeting, Larry Elliott needs to be present. This
2 will be very important when we get to talking
3 about public open meetings, because the Board --
4 if six of you get together and start discussing
5 Board issues, you have a majority and you're
6 having a Board meeting, so you need to be careful
7 about that if you're having dinner together and
8 you start discussing Board issues. And also now
9 that you have a subcommittee, which all of you
10 are a member of the subcommittee on that roster
11 and you have five members that sit that
12 committee, if three of you get together and start
13 discussing subcommittee issues, you once again
14 have a majority. And so therefore you need to be
15 conscientious of discussing Board issues and
16 subcommittee issues in small groups outside of
17 the public forum.

18 Closed meetings are going to be very
19 important for you. Closed meetings have to be
20 announced in the Federal Register, which
21 committee management handles on your behalf. And
22 the Department is the one who makes the
23 determination as to whether or not a meeting
24 should be closed. Now you all will be having a
25 number of closed meetings because protection

1 under the Privacy Act is a reason to have a
2 closed meeting, and you all will be reviewing a
3 great deal of Privacy Act information.

4 As I mentioned before, the Government in the
5 Sunshine Act is referred to by FACA and it
6 requires open meetings. And this is once again
7 where it weighs in that a majority of your
8 members -- if you're meeting outside of the board
9 room, three of you, six of you, and discussing
10 issues specific to the subcommittee or specific
11 to the Board, you are having a meeting that is
12 not in the public, and it's illegal under these
13 statutes. So please be aware of what you're
14 discussing when you meet outside of the board
15 room.

16 Once again, closed meetings (Inaudible). GSA
17 has also put forth FACA regulations. They're
18 interpretive guidelines for the management and
19 control of FACA committees, which you all are a
20 FACA committee, and HHS and this Advisory Board
21 follows those regulations. We can provide you
22 copies of them if you're interested in reviewing
23 them. I assure you that we have a great
24 committee management and they do keep us all in
25 line, but I want you to be aware that you're

1 bound by those, and if you're interested in
2 seeing any of them, we can share them with you.

3 As you know, EEOICPA established -- directed
4 the establishment of the Advisory Board with
5 certain duties, and the President established the
6 Advisory Board through Executive Order 13179.
7 And just a quick review of your duties under
8 EEOICPA and the Executive Order, EEOICPA required
9 for the dose reconstruction methods be reviewed,
10 as well as what you are about to undertake, which
11 is a -- to verify a reasonable sample of the dose
12 -- doses estimated, as well as reviewing and
13 advising on the scientific validity and quality
14 of dose estimation. So just a review of what
15 y'all are doing, and then that was also
16 reiterated by the President in his Executive
17 Order.

18 And finally, the EEOICPA SEC duties is to
19 advise the President whether there's a class of
20 employees at a DOE facility who were likely
21 exposed to radiation. And just as a reminder,
22 the President reiterated that in his Executive
23 Order, and also just a reminder that you all do
24 report to the Secretary of Health and Human
25 Services, you give advice to the Secretary of

1 Health and Human Services, not the President, in
2 accordance with the Executive Order establishing
3 the Board. And I will take any questions, and
4 hopefully that was short enough to get us back on
5 time track a little bit. And all the better if
6 there are no questions.

7 DR. ZIEMER: Questions for Liz?

8 MS. HOMOKI-TITUS: I know you guys have seen
9 this a few times, so I was trying to keep it
10 quick and just give you a refresher.

11 DR. ZIEMER: Yes, Henry Anderson has a
12 question.

13 DR. ANDERSON: Could you go back one?

14 MS. HOMOKI-TITUS: That might be beyond me.
15 How do I go back?

16 (Pause)

17 MS. HOMOKI-TITUS: What's your question while
18 I'm getting back to it?

19 DR. ANDERSON: Basically my question was
20 about the appointment, and it says all of the
21 duties were assigned to the HHS Secretary except
22 the appointment of Board members.

23 MS. HOMOKI-TITUS: Right, the appointment of
24 Board members --

25 DR. ANDERSON: And we have ac--

1 MS. HOMOKI-TITUS: -- and the Chairman.

2 DR. ANDERSON: We've actually gotten two
3 appointments.

4 MS. HOMOKI-TITUS: You've gotten two
5 appointments?

6 DR. ANDERSON: I mean we got a White House
7 appointment letter and notice, and then we also
8 got a Secretary appointment, and for some of us,
9 this is our last meeting, so --

10 MS. HOMOKI-TITUS: The Secretary's
11 appointment was -- or wasn't an appointment; it
12 was a welcome to the Board. The -- your actual
13 appointment comes from the White House. The
14 White House makes these determinations. Larry
15 may want to address that, as well.

16 MR. ELLIOTT: I would like to speak to this a
17 little bit.

18 DR. ANDERSON: Yeah, if you can.

19 MR. ELLIOTT: The White House appoints the
20 members to this Board. The President retained
21 the authority and didn't transfer that or
22 delegate that in the Executive Order. That comes
23 from the statute. The appointment letter that
24 you got from the Secretary just confirms --
25 reconfirms, I guess, that the White House has

1 appointed you and you're serving on this Board.

2 Now Dr. Anderson, you made a comment a moment
3 ago that this may be the last meeting for some of
4 you. That's not the case, until you hear from
5 the President or from the White House that you
6 have been relieved from service and somebody else
7 is appointed to take your place. You serve at
8 the pleasure of the White House until they
9 appoint a new person or you decide you want to
10 resign from the Board.

11 DR. ANDERSON: So will we get a new letter
12 from the -- from HHS? 'Cause it said my
13 appointment expires in -- in August.

14 MR. ELLIOTT: It said your appointment
15 expires in August, but you're Presidentially
16 appointed, and that supersedes the comment or the
17 sentence in that HHS appointment letter. So
18 until you are replaced by Presidential
19 appointment, you continue to serve. Or unless
20 you decide, as Sally Gadola had decided that she
21 could no longer serve.

22 DR. ANDERSON: So will we get new appointment
23 from the HHS for our four-year term?

24 MR. ELLIOTT: That's unknown until the White
25 House determines what they're going to do about

1 the appointments that are up at this point in
2 time. They could decide not to do anything at
3 this point in time and just let that ride. They
4 can let it ride into next year, and next year
5 there'll be eight members of this Board that
6 would be sitting at the table that were beyond
7 their appointment, perhaps. You un-- see what --
8 understand?

9 DR. ZIEMER: Could I also comment, and I
10 think this has been a point of confusion to all
11 the members of the Board. Other advisory groups
12 within HHS, most of which are appointed by the
13 Secretary of HHS, have specific terms. It was my
14 understanding that the Secretary of HHS had
15 intended for that pattern to be the case for this
16 Board, as well. But as Larry's indicated, the
17 overriding determination is -- lies with the
18 White House. So maybe Larry is reluctant to say
19 this, but regardless of what the Secretary of HHS
20 would like to do, it gets overridden by what the
21 White House actually does.

22 MS. HOMOKI-TITUS: That's exactly right.

23 DR. ZIEMER: I think that's the case. So in
24 a certain sense, the letter from the Secretary of
25 Health and Human Services assigning you a term

1 has very little meaning if the White House
2 ignores it.

3 DR. ANDERSON: The only difficulty is, in
4 order for me to attend -- as a State employee --
5 I have to show that I have a legitimate
6 appointment here and to share -- the letter I got
7 from HHS, which I then shared with the Wisconsin
8 administration, says I end in August.

9 DR. ZIEMER: Wisconsin doesn't recognize the
10 President's appointment as being legitimate? Is
11 that what...

12 DR. ANDERSON: Well, I mean the --

13 DR. ZIEMER: Just kidding, just kidding.

14 MR. ELLIOTT: We can work with that.

15 DR. ANDERSON: I need to have some kind of an
16 indication that in fact what the letter said --

17 MR. ELLIOTT: Well, we'll let --

18 DR. ANDERSON: -- that term doesn't end.

19 MR. ELLIOTT: Right. We can work with that
20 and get committee management office to give you,
21 for the State, a reading that will say that the
22 White House takes precedence over what the
23 Secretary's appointment letter says.

24 DR. ANDERSON: That would be helpful.

25 MR. ELLIOTT: They use standard language in

1 the Secretary's appointment letter for all HHS
2 FACA appointments, and that's what caused this --
3 this confusion. The way I think this will
4 happen, the White House is considering now what
5 it's doing -- going to do, is my understanding,
6 with regard to the first four members whose
7 appointments expire this month. I don't know
8 when they're going to make a decision on that.
9 They work at their own pace. So --

10 DR. ZIEMER: But the absence of a decision --

11 MR. ELLIOTT: The absence of a decision means
12 you're serving at the pleasure of the White House
13 and you continue to serve until you hear
14 otherwise.

15 DR. ANDERSON: Yeah, I guess I just need some
16 written confirmation of that because they log it
17 in.

18 MR. ELLIOTT: I understand.

19 DR. ANDERSON: It's just like with a grant,
20 your grant expires, and if you don't tell them
21 you got a new grant year, they close it out and
22 the staff get notices, everything goes.

23 MR. ELLIOTT: I understand. We'll -- we'll -

24 -

25 DR. ANDERSON: You know, just some --

1 MR. ELLIOTT: We'll work with committee
2 management on that and get you what you need.

3 DR. ANDERSON: Some -- just something brief.

4 DR. ZIEMER: Jim Melius.

5 DR. MELIUS: Back to Privacy Act issues, it
6 seems to me that -- I'm trying to understand how
7 this affects us procedurally, 'cause there's a
8 balance between us functioning open to the public
9 and -- and transparency to our process at the
10 same time we have to deal with in-- you know,
11 individual claims records that, for example,
12 we'll be reviewing as part of our review of the
13 dose reconstruction activities of -- of NIOSH.
14 So --

15 MS. HOMOKI-TITUS: I believe a lot of that
16 will be addressed when the subcommittee makes
17 their presentation on the procedures that they
18 have agreed to and are asking the Board to
19 approve. We did have a discussion about that
20 yesterday during the subcommittee meeting. So if
21 you can hold your question until that point, we
22 can come back and readdress it if you're still
23 concerned.

24 DR. MELIUS: Okay, that's fine.

25 DR. ZIEMER: Insofar as individual cases are

1 being dealt with and you have that issue. If
2 you're talking about a broad report, the
3 statistical numbers and so on with no individual
4 cases being dealt with, then it'll be a different
5 story.

6 DR. MELIUS: No, no, I --

7 DR. ZIEMER: We're prepared to make some
8 recommendations.

9 DR. MELIUS: Okay, that's -- my understanding
10 -- I was just saying that there's a balance there
11 and we've got to --

12 DR. ZIEMER: Right.

13 DR. MELIUS: -- understand how Privacy Act
14 works.

15 DR. ZIEMER: Okay. Other questions?
16 Comments?

17 (No responses)

18 DR. ZIEMER: Thank you, Liz.

19 MS. HOMOKI-TITUS: Thank you.

20 CONFLICT OF INTEREST, QUALITY ASSURANCE PLAN,
21 ACCESS ISSUES

22 DR. ZIEMER: Now we actually have three
23 presentations from the Board's contractor, SC&A.

24 John Mauro's going to kick this off, and then
25 Joe Fitzgerald will follow. Is Steve here, also?

1 DR. OSTROW: Yeah, I'm here.

2 DR. ZIEMER: Oh, there he is. Okay, so we
3 have -- we have three presentations, and John I
4 believe is going to kick it off and then he'll
5 pass it on. Or are you going to kick it off?

6 DR. MAURO: Joe will start off.

7 DR. ZIEMER: Joe is going to kick it off,
8 okay. Very good, okay. Thank you.

9 MR. FITZGERALD: Well, thank you. I know you
10 have a tight schedule so we wanted to try to make
11 this as efficient as possible, and I appreciate
12 the opportunity.

13 We last spoke to the Board in April about an
14 issue we felt some concern over, which was the
15 question of information or data access. And you
16 know, we now have a few months of experience. We
17 have three out of I think four site profile
18 reviews that we've been working on that are near
19 completion. And we felt it would be a good
20 opportunity to come back and mostly give you the
21 on-the-ground perspective and experience, and
22 also I think raise some issues that we would
23 certainly want the Board to be aware of and to
24 perhaps address in order to expedite these
25 reviews.

1 This just comes from our background
2 documentation, the task order, the procedures. I
3 won't go through this in detail, except to note
4 that, you know, the charter that we're operating
5 under -- and we discussed this before --
6 certainly was to look comprehensively at the
7 completeness of the records. But more -- maybe
8 more importantly, to probe in a vertical sort of
9 way, talking to workers, talking to site experts
10 and looking at secondary documentation to provide
11 the kind of validation which I think would be
12 value added to the site profiles and the work
13 that's been done by NIOSH.

14 And I'd like to report, after several months
15 of doing this work, even though we're yet to
16 deliver a report and we expect to do that soon, I
17 think the charter is very sound. I think the
18 insights that we're gaining, the feedback we're
19 getting and the -- I think the documentation that
20 we're reviewing is going to be particularly
21 valuable in providing the Board I think with the
22 kind of feedback, and NIOSH with the kind of
23 feedback, that's going to I think be a asset to
24 the process. So I think this is something that -
25 - you know, in designing this I know there was

1 some thought put into it in terms of our
2 procedures. You know, there was certainly some
3 forethought of how this would work. But you
4 never really know, I think, until you actually
5 get in and start implementing. I think it's
6 proven to be a very sound approach. I just want
7 to make that clear before we go into some of the
8 speed bumps that, not surprisingly, we're trying
9 to grapple with and for which we certainly would
10 like your guidance and -- and wisdom on.

11 Not surprisingly, access continues to be an
12 issue that we're grappling with. It's -- it has
13 slowed us down -- hasn't stopped us, but I think
14 it continues to be a challenge that -- that keeps
15 us from going as fast as we'd like and keeps us
16 from perhaps probing as much as we'd like to
17 probe in terms of some of these verticals that
18 we're talking about. And again, we -- we did
19 brief up on this general issue back in April. I
20 think the Board agreed to ask that a letter be
21 drafted for the Secretary at HHS and that has
22 since gone over to DOE in July. And I think the
23 real purpose of the letter certainly was to alert
24 DOE that this is sort of a new group, new
25 category, new activity that had started and that

1 certainly we would need to have access and
2 clearances and what-not. And it's useful to have
3 Tom here as a facilitator. It certainly helps
4 us, as well.

5 The other -- certainly the other issue -- and
6 we're picking this up certainly from the DOE
7 sites, like Savannah River is -- they have spent
8 a considerable amount of time and effort and
9 resources to generate records in response to
10 NIOSH's request. And before we can actually get
11 any additional records or documentation, they
12 certainly -- and rightfully so -- want to
13 ascertain that we have cross-referenced our
14 request against what's been already sent over.
15 And so one thing that we've been pushing for for
16 a couple -- two, three months, is to certainly
17 have ready access to the NIOSH recovered database
18 -- recovered file database. And as of last week
19 we've been pretty much read into it and can
20 navigate the search engine for those files. And
21 that's going to certainly make it possible for us
22 to do that and to then, you know, determine what
23 records we don't have. So that's been, I think,
24 a major milestone.

25 And certainly we've been looking at some of

1 these specific sites like Savannah River, and one
2 issue that's coming up very quickly is we
3 certainly need to make use of the process laid
4 out by the MOU, make sure that we can ask for
5 these records and ask for the interactions at the
6 sites and have that supported by the resources
7 that have been set aside for the MOU. Very
8 clearly, and not surprisingly, but we're hearing
9 back from points of contact is that, you know,
10 want to cooperate, but someone has to pay the
11 contractors for the time that they're going to
12 spend with us. And I think (Inaudible) you
13 raised this issue a couple of meetings ago,
14 that's very real. I think in the DOE land that
15 the margins are such that the contracts do not
16 permit interaction without certainly exercising
17 the MOU. So certainly talking to Tom, his office
18 is ready to facilitate. I know, based on our
19 conversations with Larry and NIOSH and the MOU's
20 in place, so there's a mechanism for that.

21 A key issue I want to raise, though, is
22 certainly the Q clearance is going to be a very
23 real, on-the-ground issue. We have three sites -
24 - Y-12, Rocky Flats and the Nevada Test Site --
25 for which Q clearance is almost a must in order

1 to be able to access and really go through the
2 records, if not even get on site. I know for a
3 fact, having been to Y-12 in my past lives, that
4 certainly that's going to be a requirement to
5 really be able to look at much there. And of
6 course that's on the schedule that the Board has
7 given us in terms of these reviews. So I just
8 want to alert -- you know, the -- I just went
9 through the DOD clearance process last week.
10 NIOSH has set -- you know, put this thing in
11 motion. It's moving ahead. Okay? We went
12 through and certainly went through the clearance
13 process with DOD. I think the top secret
14 clearances are forthcoming. But that's a
15 prerequisite to going to the Q. And as Tom has
16 reminded me, since I've been out of DOE for a few
17 years, that takes some time. That may take six
18 to 12 months. So I think certainly a factor in
19 our ability to do some of the secure sites,
20 either that gets facilitated, walked through --
21 'cause based on our experience, you can do these
22 things in terms of Q clearances faster or you can
23 do them in sort of routine time. There's a big
24 difference between routine time and expedited.
25 So -- but unless something happens in terms of

1 relieving that, we're going to have some
2 difficulty in being able to accomplish reviews at
3 this time -- at those two or three locations,
4 anyway. So that's sort of the practicality.

5 It's moving probably as fast as it can, but
6 it won't move fast enough I think to get to those
7 sites in the near term, so we -- you know, there
8 may be some consideration of, you know, how we
9 schedule or pace those things to reflect that
10 reality. And I heard that a little earlier, that
11 we're not the only ones that have to deal with
12 the national security questions. So it's not
13 really an uncommon issue, but a real -- real
14 issue for us.

15 So the real -- I think the bottom line
16 question is the team is up and running. Analyses
17 I think have been very fruitful. The
18 discussions, interviews and documents that we've
19 looked at have been very useful and valuable and
20 I think they'll prove useful and valuable to
21 NIOSH, as well, and to this Board. But we do
22 have some impediments that will probably delay
23 the schedule that we've been talking about.

24 We will be able to deliver two or three
25 essential reviews. Savannah River is nearing

1 completion. We have somebody on site this week
2 conducting final interviews. Bethlehem Steel and
3 Mallinckrodt both -- being AWEs, of course, there
4 isn't as much in the way of site access issues;
5 there's no sites -- and the interviews I think
6 are more straightforward, so there really isn't
7 as much of a barrier there. Hanford may be
8 somewhat of an issue. And certainly the balance
9 of the sites, the ones I mentioned, will have
10 some security questions that may prove to be a
11 problem.

12 In terms of status -- this is a couple of
13 weeks old. Actually whenever Cori requested
14 these things to be sent in, and as I was saying
15 earlier, we now have free and unencumbered access
16 to the electronic database that NIOSH maintains,
17 and that's going to make it much easier I think
18 to look at some of the reference documents that
19 are in site profiles. However, we still have the
20 DOE access issues, and we'll certainly want to
21 work with NIOSH and DOE and Tom's office to make
22 sure that we can actually get any additional
23 documents and site access.

24 Finally, this is the last slide, what it sort
25 of comes down to is that we have in fact gotten

1 access to recovered data files. I think we're in
2 fairly solid position to wrap up the three site
3 profile reviews that we're doing now. However,
4 the clearance issue's going to be a problem for
5 at least three of the next four or five sites
6 that we're looking at in terms of the Q
7 clearance.

8 The other issue is that there may be some --
9 not may be, there will be some issue as far as
10 being able to touch all the bases as far as the
11 scope that's been laid out for the reviews in
12 terms of, you know, what information we can get
13 to without clearances and what's readily
14 available to us. And I don't think the answer is
15 certainly to limit what's been planned in terms
16 of the scope for the reviews. The reviews
17 certainly are working out where they in fact are
18 very sound and the approach is one that certainly
19 we think is a strong approach.

20 However, this question of deliverables, what
21 we in fact can give this Board, is very specific.

22 We can give this Board a final review,
23 quote/unquote, and we're interpreting that as
24 pretty much a key, one-time deliverable. And if
25 we come up, you know, ten percent short, 20

1 percent short, whatever is the impediment because
2 of the data access issue or security issue, the
3 conundrum that we have and one that we want to
4 kind of ventilate with you is how do we handle
5 that in terms of providing you the analyses that
6 you've requested, but not having what I would
7 call the final assessment, the final review,
8 something that, you know, we will still need some
9 additional work -- maybe awaiting clearances.
10 You know, maybe it'll take four or five months
11 before we have the clearances. So we want to
12 certainly tee that issue up and say we are right
13 now obliged to give you a final review with the
14 full spectrum of interviews, vertical assessments
15 and everything else that's called for. If that
16 cannot be accomplished to the full extent because
17 of these constraints, where does that leave us in
18 terms of your intent and how this should be
19 handled -- 'cause right now we're sort of looking
20 at a couple places where yeah, we might have a
21 good portion of the analyses, but not all the
22 analyses. And we don't want to presume to give
23 you half a loaf or hold something back
24 indefinitely without certainly making you aware
25 of that issue. And I guess this says it all here

1 in terms of timeliness and resource issues.
2 We're looking at the efficiencies. We've talked
3 to NIOSH about the cost efficiencies. And we
4 want to really control what right now is sort of
5 uncontrollable, because I think that's going to
6 be a factor in increasing the cost and time and
7 certainly that needs to be addressed. So -- and
8 that's pretty much it.

9 What we would like, frankly, is maybe a
10 deliberation on the snapshot of today in terms of
11 the actual experience that we now have on this
12 issue and to sort of solicit a collective, you
13 know, what -- what path would make sense in terms
14 of preserving the feedback you need, but
15 recognizing the practicalities of -- of just
16 dealing with the information issue, as well as
17 security issue. Thank you.

18 DR. ZIEMER: Thank you, Joe. Let's open the
19 floor now for questions. It looks like Tony is
20 ready to ask something, then Jim.

21 DR. ANDRADE: Okay, a few points here may be
22 helpful -- hope they're helpful. You mentioned
23 something about going back and looking at items
24 called incidents. Okay. Let's be very specific.

25 I'm not sure if you're familiar with the DOE

1 parlance, if you will, but incidents have a very
2 specific meaning versus reportable(recordable)*
3 occurrences.

4 MR. FITZGERALD: Right.

5 DR. ANDRADE: Okay. And occurrences -- and
6 occurrence reports you should have access to once
7 they're closed out to -- it's public information.

8 MR. FITZGERALD: Right.

9 DR. ANDRADE: However, if you ask for
10 incident reports, some people in some of the DOE
11 contractor sites will be much more sensitive to
12 that and they'll say okay, these are sub--
13 occurrence reporting type incidents and we hold
14 these for our own use in developing lessons
15 learned, perhaps, and -- or trying to correct --
16 self-correct issues.

17 MR. FITZGERALD: Right.

18 DR. ANDRADE: Okay? They could become
19 (Inaudible) self-reportables or that sort of
20 thing. So when you ask about incidents, you
21 might expect that sort of push back. And that's
22 just a word to the wise. Okay?

23 MR. FITZGERALD: Okay.

24 DR. ANDRADE: Clearances. If you go the
25 classical DOE route, right now it's taking DOE 75

1 days to turn a request and the final adjudication
2 back to the contractor -- 75 days. That is on
3 top of an OPM* or even FBI investigation that
4 might take a year. Okay? So we're looking at
5 two years, practically speaking.

6 Now, you mentioned that you had DOD sponsors
7 that you might actually get secret or top secret
8 --

9 MR. FITZGERALD: Top secret.

10 DR. ANDRADE: -- clearances from? Okay. I'm
11 not suggesting this as a way around, but if you
12 can provide a compelling reason to a DOD
13 sponsoring agency that you need access to special
14 caveat of information, the way it's held in the
15 DOD circles, called CNWDI -- Critical Nuclear
16 Weapons Design Information. Okay? That is the
17 equivalent to having access to DOE -- a DOE Q
18 clearance with access to signals(signas)* one
19 through ten type information. That includes
20 design information.

21 So if you can get access to CNWDI, or have
22 your sponsor give you the CNWDI caveat, once
23 you're -- you can actually transfer your badge
24 from your DOD sponsor to a DOE contractor site
25 and it will be recognized as you having access to

1 Q information. Okay?

2 So a little complicated there, but
3 nevertheless, it's -- it's the way we work with
4 all branches of the services, the Office of the
5 Secretary of Defense, et cetera. Okay? So it
6 may be a little bit easier than you think, if you
7 have that DOD sponsorship and that compelling
8 reason for the caveats of CNWDI.

9 MR. FITZGERALD: Yeah, I would have to defer
10 on the -- sort of the protocol and processes.

11 I'm -- I'm unfamiliar outside the DOE side as --

12 DR. ZIEMER: It'll be easier if you can
13 figure out what he's talking about. Otherwise --

14 MR. FITZGERALD: If it works, I'm for it.

15 MR. ELLIOTT: I need to provide a point of
16 clarification here. I'm not sure, Joe, where
17 you're coming in with a DOD sponsor. You've got
18 a DHHS sponsor to get you the top secret, so you
19 may have mis-spoken that earlier.

20 MR. FITZGERALD: Yeah, it's D-- you said DOD
21 sponsor. Actually it's -- the DOD is the one
22 that responds to the HHS sponsorship to get the
23 top secret. They're just the mechanism by which
24 the investigation's handled. It's just -- the
25 sponsorship comes from --

1 MR. ELLIOTT: DHHS.

2 MR. FITZGERALD: Yes.

3 MR. ELLIOTT: I don't think DOD is involved
4 anywhere in this process.

5 MR. FITZGERALD: Well, they are in terms of
6 actually conducting the investigation itself, but
7 --

8 DR. ZIEMER: On your behalf, though, so --

9 MR. FITZGERALD: On your behalf.

10 MR. ELLIOTT: That's news to me 'cause we've
11 been dealing with OPM/FBI.

12 MR. FITZGERALD: Right.

13 MR. ELLIOTT: DOD has never entered into the
14 HHS realm. I need to check on this.

15 MR. FITZGERALD: 'Cause DSS, the Defense
16 Security Service, actually handles a lot of
17 domestic investigations, so --

18 MR. FITZGERALD: With the new Department --
19 with Homeland Security we're seeing a whole
20 watershed change here in process, so this is news
21 I need to follow up on.

22 DR. ANDRADE: If you -- if you could -- you
23 know, like I said, this is a potential mechanism
24 to be able to access -- at least get some
25 information from the Q-cleared regime*.

1 DR. ZIEMER: Well, we can follow up on that.

2 DR. ANDRADE: Yeah, if you would. I think
3 that -- that would be really good --

4 MR. FITZGERALD: I guess before we leave the
5 topic, since you have first-hand experience at
6 Los Alamos, would you agree, though, that even
7 for a place like Los Alamos, lack of a Q or
8 equivalent would pretty much handcuff you in
9 terms of your ability to even move around, let
10 alone get information?

11 DR. ANDRADE: Right.

12 MR. FITZGERALD: Yeah. You'd be a prisoner.

13 MR. PRESLEY: (Off microphone) Do you have
14 any form of a clearance?

15 MR. ELLIOTT: Speak in the mike, please.

16 MR. PRESLEY: Do y'all have any form of a
17 clearance now?

18 MR. FITZGERALD: No, we do not, and this
19 process that NIOSH instigated with HHS
20 sponsorship actually will lead to a top secret
21 clearance probably within days, which is quite an
22 accomplishment in itself, but will fall short --
23 which I think is what Antonio was saying -- fall
24 short of what's required for the DOE complex at
25 the weapons facilities. They require a Q and

1 nothing less than a Q, and that's -- that's the
2 issue we probably have to resolve if we're going
3 to do Y-12, Los Alamos and some of these other
4 locations.

5 DR. ZIEMER: Jim, you have a question?

6 DR. MELIUS: Yeah, it's not on security, so
7 if that's -- we're done with that, yeah, I have a
8 couple of questions. And one is I guess for
9 Larry. In terms of this issue of what's a
10 report, how should the subcontr-- or the
11 contractor report their findings and what if they
12 sort of -- I guess you're sort of asking, Joe,
13 should you -- because of access or other issues,
14 cannot complete a review, would there be
15 possibility for an interim report being part of
16 the process. Is it possible like to modify their
17 task orders or something to include that? I'm
18 just trying to think within the contractual...

19 MR. ELLIOTT: Certainly. Certainly, that --
20 that -- you know, what -- you know, I think that
21 it is certainly appropriate to effect a
22 modification on a task order for a due cause,
23 just reason. And I think the Board has to come
24 to grips with -- with all of that and make some
25 decisions on how to manage this audit process and

1 -- and conserve the resources at hand.

2 DR. ZIEMER: The question of what constitutes
3 a final report is not a well-defined thing. I
4 think SC&A, for example, may say we -- we don't
5 consider it final until we've reached some level
6 of comfort in what we've been able to look at.
7 And we haven't spelled out exactly what that is.

8 We've spelled it out in very general terms, but
9 it doesn't say that you have to have a certain
10 number of site interviews or this or that. It's
11 a kind of a fuzzy end point, which is somewhat
12 dependent on Joe's group and others saying yes,
13 we have completed that and now we bring it to the
14 Board. Or if we have to do it without certain
15 components, we don't feel it's complete.

16 MR. FITZGERALD: Yeah, and my -- my --

17 DR. ZIEMER: And so that -- that's kind of
18 part of the issue, what's complete. And you can
19 go to extremes on this. You know, I had a
20 faculty member once who we kept urging him to
21 publish more. The papers were never complete.
22 Why not? Well, they were -- he was never quite
23 satisfied that he had achieved perfection. But
24 somewhere between that and doing a really sloppy
25 job, there may -- there may have to be some point

1 at which you say I'm done with this; I can't do
2 any more. Within whatever the constraints are,
3 whether they're time constraints, resource
4 constraints, access constraints, there may be
5 some point where you have to say that's as good
6 as it's going to get, folks, within some reason.

7 And you know --

8 MR. FITZGERALD: Yeah, the other reality,
9 too, is site profiles are living documents and --

10 DR. ZIEMER: They're changing.

11 MR. FITZGERALD: -- sort of begs the question
12 at some point -- for example, the construction
13 workers are added as a component, you might want
14 to at least come back with any assessment of that
15 component. But this -- this issue is -- what
16 we're looking at is going forward and seeing a
17 certain unevenness. You know, a certain -- you
18 know, we take the list that you gave us very
19 seriously as far as the agenda of site profiles
20 that -- reviews that are expected. Certain ones
21 clearly, because of the clearance issue, are
22 questionable in the near term. So those will be
23 ones that we probably can't give you much at all.

24 There were others that -- like Hanford, where
25 that won't be as major an issue, but will be a

1 issue. So we may be able to do let's say 70
2 percent of what we think would be an adequate job
3 of providing that feedback.

4 My question -- and then there's others like
5 Mallinckrodt and Bethlehem Steel I feel pretty
6 comfortable that we're -- we'll be prepared to
7 give you something before your next meeting. So
8 it's that sort of in-between situation where, you
9 know, we're not able to do what we have looked at
10 in terms of our procedures and your charter as
11 being that, you know, full analysis. And you
12 know, we're sitting here thinking well, on one
13 hand we've expended resources to produce this --
14 this much work, but we can't share it if it isn't
15 the analysis we think it should be. But you
16 know, what do we do with it in the meantime? Do
17 we wait until we get access or do we give you the
18 best we can? Certainly we don't want to do
19 damage to the scope that's been laid out. I
20 think, as we said earlier, the scope has proven
21 to be I think a valuable scope, and certainly we
22 want to be able to give you as much as we can.
23 But you know, the reality is that -- I guess it
24 wasn't foreseen in the beginning that the access
25 is not going to be uniform and comprehensive.

1 It's going to be uneven and it's going to be
2 time-based. We'll probably be okay next year,
3 maybe even sooner than that. But you know, I
4 think as Antonio was saying, the vagaries of
5 being able to get the unencumbered access to a
6 high secure site -- anyone's guess. And I -- you
7 know, the stakes may have gone up.

8 DR. MELIUS: Yeah, but -- but it seems to me
9 that -- certainly I'm personally more comfortable
10 with some of the review not being done because of
11 a security clearance issue. That's a relatively
12 straightforward --

13 MR. FITZGERALD: Right.

14 DR. MELIUS: I think when it becomes an issue
15 of the resources necessary to pay the contractor
16 for the time of their personnel and so forth
17 involved, if that becomes an issue I think it --
18 I guess I would have more concerns about that.
19 And it certainly I think puts NIOSH in a very
20 difficult position because in some sense, if the
21 resources aren't being made available for our
22 contractor to do their work, it would certainly -
23 - raises the -- you know, the appearance that
24 NIOSH is, you know, holding back and somehow
25 impeding our review of the NIOSH dose

1 reconstruction process. And I think that is --
2 puts NIOSH and puts us in a very uncomfortable
3 and very difficult position. So if -- if we're
4 going to be cutting back on what's being done in
5 terms of them having appropriate access to the
6 site and appropriate resources necessary for that
7 access in context of the MOU and the other
8 procedures worked out, then I think we -- we have
9 to be very careful about that. I think the Q
10 clearance issue is much more clear-cut and -- you
11 know, we get at some point and say well, you
12 know, 70 percent of this site profile review can
13 be done, but 30 percent we can't because without
14 the Q clearance access we just can't really
15 review certain parts of the site profile or
16 certain parts of the site. Then I think, you
17 know, modifying the task order in a way that
18 would allow an interim report and then, you know,
19 a final report at some point when the -- you
20 know, the Q clearance issue has been addressed, I
21 think that makes -- it's pretty straightforward
22 to do.

23 I also would say that -- I mean there's no
24 doubt once some of these are -- for example, the
25 site profile reviews are done, that we may want

1 to look at see what overall our procedures are
2 and then -- and learn from that experience. I'd
3 rather learn from maybe having done a little bit
4 too much than cutting back, then, you know, being
5 in a position of not having had, you know,
6 complete access and not doing all that you
7 originally thought should be -- should be --
8 should be done for that.

9 I also have a concern that -- in terms of
10 scheduling. And if I understood you right now,
11 your slides are -- what's been updated, it's
12 Mallinckrodt you now have access to the documents
13 and so forth? That's been...

14 MR. FITZGERALD: No, we -- we are still
15 waiting for additional documents from NIOSH on
16 Mallinckrodt.

17 DR. MELIUS: Uh-huh.

18 MR. FITZGERALD: We don't have everything
19 that we need to finish Mallinckrodt. We have
20 done quite a bit on Mallinckrodt and feel
21 confident we can wrap things up probably within
22 weeks, but we're still looking for some
23 documents.

24 DR. MELIUS: Uh-huh, but -- 'cause I think
25 one of the -- I mean we're going to talk about

1 this more tomorrow is this SEC petition review.
2 And if we're in the -- I mean I would hate us to
3 be in the position of having a site profile
4 review pending from Mallinckrodt at the same time
5 being in which we haven't got a report from our
6 contractor on the original site profile, and
7 NIOSH be in the position of reviewing a petition
8 based on the site profile, and us reviewing the
9 NIOSH SEC petition review. And maybe they'll not
10 be connected at all, but may be they will and it
11 would be, you know...

12 DR. ZIEMER: Larry, did you have a comment on
13 the Mallinckrodt? Or...

14 DR. NETON: (Off microphone) (Inaudible)
15 we're not aware of any documents that we owe you
16 at this point in time.

17 MR. FITZGERALD: Well, I mean -- again,
18 things are breaking pretty fast and to be fair,
19 Jim, we have -- actually now that we have access
20 to the NIOSH database as of last Thursday, we
21 have done searches against it on Mallinckrodt
22 just to see what reference documents in the site
23 profile we had -- you know, actually had access
24 to and which ones we didn't, and there are some
25 documents that we want to look at that aren't in

1 the database apparently. I think actually John
2 has the list.

3 But you know, again, this is breaking -- I
4 mean what's today, Tuesday? We -- we did the
5 search this Friday and, you know --

6 DR. NETON: (Off microphone) It sounded like
7 you were awaiting documents that we -- you had
8 asked us for and I just wanted --

9 MR. FITZGERALD: No, no, the question --

10 DR. NETON: -- to make sure --

11 MR. FITZGERALD: -- was were we all set with
12 Mallinckrodt, and my answer was no, we actually
13 needed some additional documents. But again, in
14 terms of timing, we just got access to --

15 DR. ZIEMER: It's just a matter of finding
16 out exactly where they are.

17 MR. FITZGERALD: -- the NIOSH database and
18 finding out what was in there, and then compare
19 it up against the site profile. And of course
20 what we established where there was a delta.
21 There were some documents referenced that were
22 not in the database, and certainly two days later
23 we're now prepared to ask NIOSH if we could
24 certainly have access to those documents. So you
25 know, again, a lot of this is just --

1 DR. ZIEMER: Just in real time it's just --

2 MR. FITZGERALD: -- mostly real time we've
3 gotten the ability to know what NIOSH actually
4 has in its database, so...

5 DR. ZIEMER: Let's see --

6 DR. MELIUS: I have another --

7 DR. ZIEMER: -- Mark? Oh, you have one more,
8 Jim.

9 DR. MELIUS: -- one more question, final
10 question. Is -- and this may be more for Larry,
11 but Tom Rollow's -- I think referred this to you
12 this morning, but could you explain to us this
13 issue regarding access to the sites and this
14 Memorandum of Understanding and the payment
15 mechanisms and so forth, 'cause I'm just trying
16 to understand if there's an issue or if there's
17 not an issue now or if it's a short-term issue,
18 long-term, what -- what's going on?

19 MR. ELLIOTT: There is no issue that has been
20 brought to my attention at this point in time.
21 We have been as cooperative and collaborative as
22 I think we can be in trying to respond to
23 requests. I'm a little bit disconcerted here
24 that this was -- that, Joe, you just portrayed
25 that you had -- awaiting documents from us that

1 you haven't even requested of us yet, but there
2 are -- you know, I -- the arrangement that we
3 have with DOE under our MOU is that we will
4 facilitate access. If we hear that there is a
5 push-back because of funding, a need to support
6 the access request, we'll work that out with DOE.

7 But to date we have not heard any of that, or no
8 instances have been brought to my attention. And
9 I don't believe to Tom's attention at this point
10 in time, 'cause if they were, I'm sure he would
11 have talked to me about them.

12 DR. ZIEMER: Tom seemed to indicate that the
13 -- that the field was prepared to assist in our
14 effort here, so --

15 MR. FITZGERALD: Well, with one caveat. I
16 mean -- make it very clear that understandably
17 the DOE field operations want to be assured that
18 we have cross-referenced our document requests
19 with the NIOSH database, which we were unable to
20 do until last Thursday or Friday. And it will
21 now be possible to give them that assurance and
22 actually send a request through and know that it
23 hasn't been already requested and recovered. So
24 yeah, with that caveat, I think we're in a
25 position to do so. But without being able to

1 provide that assurance, understandably the field
2 office -- or field operations were unwilling to -
3 -

4 DR. ZIEMER: Well --

5 MR. FITZGERALD: -- to respond.

6 DR. ZIEMER: -- they didn't want to do double
7 work.

8 MR. FITZGERALD: No, no, and that's
9 understandable. I don't disagree with that.

10 DR. ZIEMER: Henry?

11 DR. ANDERSON: Yeah, I just wanted -- more
12 for the Board, it would seem to me that a interim
13 report -- what we want to do is be sure that you
14 don't expend the resource, that you don't put
15 extra effort into what you can do on a site --

16 MR. FITZGERALD: Right.

17 DR. ANDERSON: -- and then say well, we can't
18 do the rest of this, and then if --

19 MR. FITZGERALD: Right.

20 DR. ANDERSON: -- subsequently access becomes
21 available, you then turn around --

22 MR. FITZGERALD: Right.

23 DR. ANDERSON: -- and say well, we need more
24 resources. I'd rather say let's reserve the
25 resources and when the clearances -- which

1 ultimately they will come through -- then you
2 would complete that, but we would just --

3 MR. FITZGERALD: Right.

4 DR. ANDERSON: -- kind of hold your -- your
5 contract resources, but we would perhaps want to
6 know what you had to date. Now we'll have the
7 first ones coming up so we'll get a sense of, you
8 know, how -- you know, where -- where was the
9 confirmation strongest --

10 MR. FITZGERALD: Right.

11 DR. ANDERSON: -- if it was on the interviews
12 or whatever. And you may say gee, you know, on
13 the basis of the three we've done or two you've
14 done, that seems to be a very important component
15 of the assessment and when we talked to people on
16 site, that --

17 MR. FITZGERALD: Right.

18 DR. ANDERSON: -- you know, the blinders came
19 off and it was very obvious as to what was going
20 on, so --

21 MR. FITZGERALD: Yeah.

22 DR. ANDERSON: So that's -- I wouldn't -- I
23 wouldn't want you to --

24 MR. FITZGERALD: Right.

25 DR. ANDERSON: -- redeploy resources to do

1 your site, you know, profile assessments, put
2 more effort onto this, and then -- because you
3 can't do it here.

4 MR. FITZGERALD: Well, we -- we -- we do --
5 you know, we have a challenge, and I think that
6 challenge has been re-emphasized by NIOSH that,
7 you know, we have a explicit budget that we have
8 to operate within, and so essentially it's a zero
9 sum game --

10 DR. ANDERSON: Yeah.

11 MR. FITZGERALD: -- that we have to find a
12 way to conduct these reviews within that set
13 budget. And if we expend those resources, those
14 resources are not available to review other sites
15 or to do a broader scope. So you know, that -- I
16 don't disagree. I think it's going to have to be
17 managed very carefully or otherwise it's going to
18 truncate the entire process.

19 DR. ZIEMER: Robert, then Mark.

20 MR. PRESLEY: You had two or three more down
21 here before me.

22 DR. ZIEMER: Yeah. Oh, okay. Mark,
23 (Inaudible)?

24 MR. GRIFFON: Well, I just wonder -- I guess
25 the funding question has been answered here, but

1 I -- I'm looking at the first bullet up hereon
2 your considerations, and the last phrase there
3 concerns me a little bit that there seems to be
4 some questioning of the comprehensive scope of
5 the reviews. Is that -- I mean are there issues
6 about what kinds of -- of data or the extent of
7 data that you're looking to access as compared to
8 the scope within the task order, or is that
9 becoming an issue? Because we -- we as a Board
10 haven't been put in -- that issue hasn't been
11 raised to us and I'm just wondering how -- if
12 there is that issue, how does that get resolved?

13 It seems --

14 MR. FITZGERALD: Well --

15 MR. GRIFFON: -- seems there like you're
16 referring to you -- you've had these
17 conversations with NIOSH staff -- I don't know,
18 I'm...

19 MR. FITZGERALD: -- NIOSH is the contracting
20 organization, and what we have to look at is the
21 expenditures and the burn rate and certainly one
22 issue is to sort of compare scope in terms of
23 what's being addressed and the depth as it's
24 being addressed. Obviously this could be -- each
25 profile review could be, you know, months and

1 months and months, you know, so you have to draw
2 a line. And so the discussion's been pretty much
3 to assure that there isn't -- I think the term of
4 art is a scope creep where you're not necessarily
5 beginning to move out of what is a defined scope
6 for the review itself. And so those discussions
7 have been involved in terms of, you know, what is
8 in fact this scope that we're trying to
9 accomplish.

10 Now the scope that we're operating against is
11 the scope that's been laid out I think very
12 clearly in the original task order and in the
13 site profile procedures which this Board
14 approved. But you know, again, they have not
15 been tested in the field, so to some extent this
16 is the sort of proof in the pudding of, you know,
17 how this actually is going to be implemented.
18 We're finding of course some things take more
19 resources than originally envisioned.
20 Interacting with site experts not surprisingly
21 takes resources. And so we're gaining this
22 feedback and passing that feedback to NIOSH,
23 making sure they're aware of, you know, how this
24 is going along. So there's been some I think
25 discussion on scope, but certainly that's one

1 issue that clearly the Board should be aware of
2 and certainly that's going to be something that
3 will come up in the reviews that you'll be seeing
4 over the next month or two in terms of what
5 should be the model, as far as how deep you go in
6 these verticals and what kind of analyses is
7 appropriate for these audits. But...

8 DR. ZIEMER: And let me add to that, also,
9 Mark. I think at the front end of the process,
10 this Board or those who were acting in our behalf
11 in terms of the original cost estimates, did an
12 estimate that for a certain number of dollars you
13 could do a certain number of reviews. And
14 likewise, I think the contractor bid sort of in -
15 - I don't want to say in the dark, but at least
16 without all the information available as to what
17 that would entail. Now as we get into the real
18 issues and what it takes to do it, we may find
19 out that the resources available are only
20 sufficient to do -- let's say ten instead of 12,
21 or something like that.

22 MR. FITZGERALD: Well, certainly --

23 DR. ZIEMER: We're sort of learning as we go,
24 both of us, the Board and the contractor, as to
25 what it takes in time and effort and resources to

1 do these reviews.

2 MR. GRIFFON: I guess part of what I'm --
3 what I'm inquiring is what's the decision-making
4 process? 'Cause I don't think the Board's
5 learning very much about that process. I mean I
6 -- you know, we -- we've seen maybe that there's
7 some questions on the complexity or the depth of
8 the scope, you know. What -- what in particular
9 and who -- who makes those -- I understand
10 there's budget constraints and that NIOSH has the
11 --

12 DR. ZIEMER: No, I think --

13 MR. GRIFFON: -- is the contracting officer -
14 -

15 DR. ZIEMER: -- the Board has to make --

16 MR. GRIFFON: -- but we've been very clear on
17 this Board that we -- we --

18 DR. ZIEMER: The Board has to determine --

19 MR. GRIFFON: -- have the say on the scope.

20 DR. ZIEMER: -- if the tasks go -- is to
21 change, and I think --

22 MR. GRIFFON: Right, so we can't --

23 DR. ZIEMER: -- Joe's giving us kind of a
24 heads-up that -- what issues are emerging and --

25 MR. GRIFFON: But I don't know if we can wait

1 for final reviews to come out and then -- I mean
2 maybe that goes back to that question of interim
3 reports, but I -- I mean I think if there's
4 issues on scope creep -- is that the -- you know,
5 potent-- word you use, you know, if those issues
6 are there now, I think we need to maybe resolve
7 them or clarify what -- you know...

8 MR. FITZGERALD: Well, I think the
9 considerations really touch upon I think some of
10 the factors, one of which is the zero sum on
11 resources, that we have to plan within those
12 resources. That's -- that's one issue. The
13 other issue is -- you know, again, we're -- we're
14 establishing on the ground this issue of, you
15 know, what the scope should be. It's defined
16 certainly in the procedures, but in practice, how
17 far do you go and all that? And certainly this
18 question of what do you do as a contingency if in
19 the interim you can't touch those bases? And
20 certainly -- I think Jim was mentioning, you
21 know, certainly some approaches to -- but there's
22 many -- probably many more. That's why it sort
23 of left it as considerations, but those are all -
24 - those three or four factors are all key factors
25 that I think constrain what that solution would -

1 - would be. And I -- we just didn't want to go
2 so far and -- and presume what the Board would
3 want to give us as guidance on this. You know,
4 right now we're at the juncture where it would be
5 very helpful to understand what -- what would
6 make sense.

7 DR. ZIEMER: Robert?

8 MR. PRESLEY: Joe, you might think about
9 changing your clearance from a Q to an L. In my
10 estimation --

11 MR. FITZGERALD: I haven't got the Q yet.

12 MR. PRESLEY: If you -- if you've got a Q,
13 then you're fine.

14 MR. FITZGERALD: Right.

15 MR. PRESLEY: But the people that are there
16 really don't have a need to know for design data.

17 MR. FITZGERALD: Right.

18 MR. PRESLEY: Most of the documents are
19 accessible at a lower level. It takes a whole
20 lot less time to get a L than it does a Q.

21 MR. FITZGERALD: I guess I would defer to
22 those who have crossed that line and had -- my
23 experience with -- I had a Q for two decades, and
24 my experience is certain places in the complex,
25 even with a Q, without a need to know, I would

1 sit out in the waiting room for hours. And so
2 can you imagine not having a Q? I suspect you
3 couldn't get past the gate, particularly these
4 days. I'm just saying from practical experience,
5 for certain sites like Y-12 and what-not, it's
6 going to be very difficult to accomplish our
7 mission without Q clearance, and I think that's
8 all I can say about that. Other sites, not so.

9 MR. GRIFFON: My experience is similar. I
10 mean I had the L and then had to wait for an
11 upgrade to the Q. The problem I ran -- a lot of
12 the records that I had to review didn't need more
13 than an L clearance. The problem is that they
14 were in file cabinets or --

15 MR. FITZGERALD: Right.

16 MR. GRIFFON: -- placed in with Q-cleared --
17 right -- so you couldn't have access to those
18 areas, you know.

19 DR. MELIUS: Nobody told them when they set
20 up the filing system.

21 DR. ZIEMER: Jim, did you have another
22 comment?

23 DR. MELIUS: Yeah, I have two -- two
24 comments. One is a contracting one and somebody
25 from NIOSH can correct me, but if we did modify

1 the task orders for -- allow for an interim
2 report, I would foresee -- and let's use the Q
3 clearance issue 'cause I think it's the most
4 straightforward -- that our contractor could make
5 the case that when they originally bid on this,
6 they assumed they could do this all in one visit
7 or two visits or whatever it is, that there would
8 be extra costs involved if they had to spread
9 these out over -- over time. So I think we have
10 to, you know -- you know, laying the burden on
11 them is to show that that was their intent in how
12 they made their original bid, but I think we'd
13 have to be ready to allow for some modification
14 in the -- the cost of the contract, should these
15 get split up into -- especially if it gets split
16 up in more than one interim report, if there's --
17 some of this comes across piecemeal in some way
18 or whatever.

19 The other issue I'd like to get at is sort of
20 the schedule for when we will be, you know,
21 seeing some of the reports from the contractor,
22 because I think some of these issues are going to
23 be easier for us to deal with going forward once
24 everyone's seen a report and we've had some time
25 to discuss it. So you know, can we assume that

1 for our next -- our October meeting that
2 Bethlehem Steel and Mallinckrodt will be
3 complete? How about Savannah River?

4 MR. FITZGERALD: We are on site this week. I
5 think that's a possibility, although -- you know,
6 again, you know, the review process through --
7 we're going to send the report through NIOSH and
8 then to the Board. That takes time and that
9 process itself may, you know, take weeks, so that
10 part of it I can't account for. I think we'll
11 certainly have the drafts that can be transmitted
12 to NIOSH for review by then.

13 DR. MELIUS: Are we going to talk about the
14 review process tomorrow when we're talking about
15 -- okay. Then I'll -- I'm just trying to figure
16 this out in terms of -- 'cause I think once we
17 have, you know, one big site like Savannah River,
18 and then the two smaller sites, I think we may
19 have a better handle and better able to talk
20 about some of these issues going forward and so
21 forth.

22 MR. FITZGERALD: Small sites like the AWEs
23 are much different than the larger, more secure
24 sites -- DOE sites.

25 DR. MELIUS: Yeah.

1 MR. FITZGERALD: I mean just by nature, we --
2 we have much more ready access on the AWE
3 information.

4 DR. MELIUS: Yeah. And -- but Savannah River
5 I think would be a good -- if that's the first
6 one done, we can work from there.

7 DR. ZIEMER: Other comments or questions?

8 (No responses)

9 DR. ZIEMER: Thank you very much, Joe. We
10 appreciate that and Steve -- well, we're flexible
11 here and Steve --

12 DR. MELIUS: You have 30 seconds.

13 DR. ZIEMER: -- Steve's going to do both the
14 organizational conflict of interest plan and the
15 quality assurance plan. Right, Steve?

16 DR. OSTROW: (Off microphone) Yeah,
17 (Inaudible).

18 DR. ZIEMER: Right.

19 (Pause)

20 DR. OSTROW: Okay, first of all, I'm not John
21 Mauro. I'm Steve Ostrow and I work with John,
22 and I'm going to speak first of our conflict of
23 interest plan.

24 (Pause)

25 All right, we have a conflict of interest

1 plan. It's a little bit misnomered. It's not
2 just an organizational conflict of interest.
3 It's also personal conflict of interest. And the
4 -- it's basically a formal plan to assure that
5 everything is done aboveboard and we don't have
6 any conflict of interest with the organizations
7 involved, SC&A and subcontractors and individual
8 people involved in the project.

9 The basic mandate for the conflict of
10 interest goes back to the government FAR
11 regulations, and we translated it then into a
12 procedure that we can follow. And the purpose is
13 to basically assure that we can render impartial
14 judgment and impartial advice to the advisory
15 committee.

16 And we have -- the organization
17 responsibilities, we have -- the plan's fairly
18 long, but it boils down to a few things, that --
19 we committed that we're not going to bid on or
20 perform any work for NIOSH or ORAU or any of
21 their contractors. We won't accept any work from
22 DOE or DOE contractor that has to do with
23 radiological issues. And that we will -- if any
24 gray areas, we'll consult with the Board for
25 guidance to resolve them.

1 The individuals -- as part of our procedure,
2 everybody on the project -- we have 36 total
3 member -- individual members on the project. Not
4 everybody's working and giving time, but
5 potentially we have 36 people who could work on
6 the project. Everyone was given a copy of the
7 OCI plan. They have to acknowledge that they
8 received it and they understand it. And they
9 sent to the plan administrator a questionnaire that
10 they filled out about their past activities
11 related to things like what sites they worked on
12 and what projects they worked on. The
13 administrator then makes a determination of
14 whether they can have basically unlimited
15 clearance to work on anything in the project or
16 whether there's any restrictions on what they can
17 work on.

18 These are just copies of the -- on the left
19 of the acknowledgement form that the person fills
20 out to acknowledge they read the plan and
21 understand it. On the right-hand side are the
22 five questions that people have to answer, and
23 it's probably easiest to read this in the handout
24 than on the screen. It's a little bit difficult.

25 But basically any "no" responses -- or any "yes"

1 responses have to elaborate with attachments.

2 And some of the criteria that we have that
3 individuals -- if they have served as an expert
4 witness on any Worker Compensation cases,
5 radiation-related, on behalf of DOE or DOE
6 contractors, they're precluded. If they're
7 currently working for NIOSH, ORAU or contractors
8 under that, they're also precluded from working
9 on the project. If they have worked for NIOSH,
10 ORAU or companies teamed with ORAU on dose
11 reconstruction in the past, we look at it
12 carefully. If they worked for DOE or DOE
13 contractors in the past, or have worked on DOE
14 sites or contractor sites, we have to look at it
15 carefully at what they were actually doing.

16 The -- we document this pretty well. We
17 maintain -- after we make a determination, we
18 maintain in our files in the SC&A headquarters --
19 we have a secure file -- all sorts of information
20 about the plan, the individual responses, the
21 findings on the individuals, what sites they
22 cleared for or not cleared for. And the idea is
23 to have it sort of a transparent process, that if
24 there -- anyone wants to -- authorized wants to
25 look at it, we have all the information available

1 for audit.

2 In addition to the individual, we also have
3 corporate conflict of interest certifications
4 that the different -- SC&A and its
5 subcontractors, that they're not engaging in any
6 outside -- different contracts or work which may
7 conflict with the work we're doing on this
8 particular contract.

9 And we maintain two summary lists that are
10 available to the Board -- or will be, if... The
11 first one is just a summary of the yes and no
12 responses to the five questions that we ask for
13 each individual. We have it by individual, and
14 I'll show -- one of the last slides shows this
15 and their yes and no to the five questions -- and
16 the certification review results -- restricted,
17 unrestricted or precluded from a particular site.

18 And the other list is restricted site list, so
19 all -- so it's the same information, but in a
20 different format -- for each of the 36
21 individuals, where they may -- the sites where
22 they may not serve as the lead reviewer.

23 Just a little statistics that -- these are
24 the five questions, and I just will summarize
25 them -- the questions are longer, but the first

1 one, has a person worked -- or working now or
2 have worked on the dose reconstruction contract,
3 and two people had worked on it in the past.

4 Second one, anybody an expert witness in
5 Worker Comp, and zero, which is the way it should
6 be 'cause that person wouldn't be able to
7 participate in anything if they did do that.

8 Third, working for a DOE, DOE contractor,
9 AWE, et cetera. Not surprisingly, a lot of the -
10 - 27 out of 36 have, because pretty much anybody
11 in the nuclear industry who would work on the
12 project had in the past some experience with
13 contractors or DOE, otherwise they wouldn't be
14 qualified now to work on the project.

15 And same thing number four, working a DOE or
16 AWE site, and in the past a good fraction of work
17 -- done some work on the site.

18 And finally, five, current or past contracts
19 or financial relationships resulting in actual or
20 perceived COI. That's also zero because you
21 wouldn't be able to work on the project if you
22 said yes to this one.

23 Also in statistics, this has been -- this is
24 two weeks old -- so right now, out of the 36, we
25 have 21 unrestricted and they can work on

1 basically any -- anything; 15 restricted, zero
2 precluded, and nobody's pending review.

3 The plan also has sort of a general provision
4 it has to be somewhat self-policing because you
5 can't anticipate, when you're filling out this
6 form ahead of time, exactly what you're going to
7 be reviewing in the future, so people have to use
8 -- and task leaders have to use a little bit of
9 judgment. Obviously you can't review any work
10 that you have personal knowledge of, that you had
11 worked on, you know, in one of your past
12 assignments, so you have to be sort of self-
13 policing, the people on the project (Inaudible).

14 We stress that if there's any doubt, they have
15 to consult with the COI officer and then if that
16 can't be resolved, then we'd take it to the Board
17 for a determination. But people have to be
18 vigilant on this.

19 This is a first summary list, just a quick
20 look where we have the five ques-- all the people
21 in the project, organizations they're from, yes
22 and no to the five questions, date of the reviews
23 and whether it's any restrictions on their
24 participation in any aspects of it. This is like
25 a quick list you can go down.

1 There's always backup information of course
2 in the files. If you pick a particular person,
3 he has a folder in our files that has all the
4 backup that exp-- you know, goes into the details
5 on this. That's the second page of it.

6 This is the second list. This is also by
7 person and lists the particular projects where
8 people -- or sites where people may not have
9 access to serve as a lead reviewer. So you can
10 see, for example, one person is precluded from
11 working on Fermilab and Los Alamos, for example,
12 because that person had past experience at that
13 laboratory. The person can still be a subject
14 expert. You know, it's a valuable resource to
15 have somebody who actually worked at one of these
16 sites, but that person cannot be a lead reviewer,
17 responsible for the review. This is the second
18 page of the same list.

19 And finally, this is also going to the list,
20 this is just the different site acronyms that we
21 use and the organizations involved. So that was
22 -- that's a quick overview of the conflict of
23 interest draft plan that we've been operating
24 with.

25 Before I go into the QA portion, this is a

1 good point to ask for some questions now on the
2 conflict of interest stuff.

3 DR. ZIEMER: Yeah, let me point out to the
4 Board that the conflict of interest plan is a
5 deliverable, and requires our acceptance and
6 approval. The slides are not the plan. The
7 slides are a summary of the plan. The plan was
8 e-mailed to you earlier. I don't know if you've
9 brought copies with you or -- and if you -- what
10 we need to do -- we'll have questions and so on,
11 but we'll need a motion to accept or approve the
12 conflict of interest plan. But let's open the
13 floor for questions first.

14 DR. OSTROW: I was going to make a comment.
15 In addition to the comments of the Board, we
16 personally would like to make a couple of
17 modifications, mainly of the housekeeping things.
18 We read it and looked it and there's a couple of
19 things --

20 DR. ZIEMER: On the actual document itself.

21 DR. OSTROW: Yeah, it's mainly in the
22 editorial --

23 DR. ZIEMER: We'll need to know what those --

24 DR. OSTROW: Of course.

25 DR. ZIEMER: -- changes are, of course, but -

1 -

2 DR. MAURO: (Off microphone) (Inaudible) I
3 believe --

4 DR. ZIEMER: John, you'll --

5 MR. ELLIOTT: Use the microphone --

6 DR. ZIEMER: -- need to use the mike for our
7 recorder here. Or use one of those mikes there.
8 Just grab one there.

9 DR. MAURO: I just wanted to make a point
10 that I believe eventually material that we've
11 been summarizing here by way of conflict of
12 interest will be going up on a web site.
13 (Inaudible) I believe there's conflict of
14 interest information regarding your -- regarding
15 NIOSH's contractors. There's certain information
16 that's on the web site as full disclosure.

17 DR. ZIEMER: Right.

18 DR. MAURO: We will be doing the same thing
19 once we reach the point where it's appropriate.

20 DR. ZIEMER: Right.

21 DR. MAURO: So for example, the lists --

22 DR. ZIEMER: Well, I think once the Board
23 accepts it as the plan, then it's -- would
24 certainly be appropriate at that point. Yeah,
25 thank you.

1 Are there questions at this point? Henry?

2 DR. ANDERSON: I'm assuming that NIOSH has
3 looked at it. I don't -- I mean -- I would be
4 interested to know if you have any comments about
5 it.

6 MR. ELLIOTT: We've read it --

7 DR. ANDERSON: You've got a lot of
8 experience.

9 MR. ELLIOTT: We've read it, but it's your
10 decision --

11 DR. ANDERSON: Yeah.

12 MR. ELLIOTT: -- it's not ours. We have no
13 input to this.

14 DR. ZIEMER: Thank you.

15 DR. OSTROW: Well, could I just make one
16 little statement? We -- the plan itself
17 basically is very similar to what we put in our
18 proposal. We made a few modifications to it,
19 it's basi-- it's 95 percent the same, just maybe
20 better English, hopefully. And the...

21 DR. ZIEMER: Wanda?

22 MS. MUNN: I'm assuming we will have hard
23 copies of the plan and whatever changes have been
24 --

25 DR. ZIEMER: Cori --

1 MS. MUNN: -- undertaken.

2 DR. ZIEMER: -- just went to check to see if
3 there's hard copy available for you now in case
4 you didn't bring your e-mailed copy.

5 MS. MUNN: No, I downloaded it, but I didn't
6 even print it.

7 DR. ZIEMER: We can defer action on the plan
8 until the work session tomorrow and (Inaudible)
9 sure that we have hard copy by then.

10 MS. MUNN: I would prefer that.

11 UNIDENTIFIED: I have a hard copy.

12 DR. ZIEMER: You have a hard copy there that
13 --

14 UNIDENTIFIED: It's got some mark-ups on it.

15 DR. ZIEMER: -- could be made -- but let's --
16 let's -- is it agreeable, we'll just defer the
17 action to the -- tomorrow's working session so
18 that we make sure everybody has a hard copy and
19 then we'll get the what, editorial or minor
20 modifications?

21 DR. OSTROW: I haven't actually made the
22 editorial comments yet. I thought we would do it
23 the other way around and see if the Board had any
24 comments, then the final product of the editorial
25 stuff. I thought I'd do it the other way around.

1 MR. ELLIOTT: Tony, is yours clean?

2 DR. ANDRADE: Yes.

3 DR. MELIUS: I have a clean one, too, if
4 you...

5 MR. GIBSON: Both this and the QA plan, as
6 well.

7 DR. ZIEMER: Okay, let's -- nonetheless,
8 let's defer action at least till we make sure
9 everybody has a hard copy and then we can mark in
10 -- who has your changes then on this one?

11 DR. OSTROW: No one has, I didn't make them
12 yet.

13 DR. ZIEMER: Oh, you haven't made them yet.

14 DR. OSTROW: I mean I have in the mind
15 something I want to do, but I thought I'd do it
16 the other way around and get the Board's comments
17 --

18 DR. MELIUS: Yeah, but we really need to
19 approve what we approve and what's --

20 DR. ZIEMER: Right.

21 DR. MELIUS: -- final, and --

22 DR. ZIEMER: Right.

23 DR. MELIUS: -- either -- you know.

24 DR. ZIEMER: Well, we'll get -- we'll get
25 this copied. You'll tell us what changes you

1 want to make before we approve it then.

2 DR. OSTROW: Okay.

3 DR. ZIEMER: Okay. So we'll defer the actual
4 action till either later this afternoon or
5 tomorrow then, if that's agreeable.

6 DR. OSTROW: Fine.

7 DR. ZIEMER: Thank you. You want to proceed
8 then with the other -- quality assurance
9 information then?

10 DR. OSTROW: Sure. Okay. This is the second
11 presentation on quality assurance on the project.

12 And this basically is nothing new or novel, that
13 all the work we do and I'm sure the work other
14 people do in organizations is governed by a
15 quality assurance plan. You have to have a -- we
16 wrote a project-specific plan that is --
17 basically governs how the process is done and it
18 reflects the job requirements, in addition to the
19 regulatory requirements that are on the project.

20 And basically it controls and documents all
21 aspects of the project.

22 The goal is to do everything consistently,
23 according to the contract requirements and
24 regulatory requirements, and also to provide a
25 record of what's been done so that in the future

1 if somebody asks well, why did you do this and
2 this or how did you do this and this or what did
3 you actually do, the record is there. You can go
4 back and take a look and the process is clear and
5 transparent. And it also provides an order trail
6 for our work to do, so that's the basic purpose
7 of a quality assurance project plan.

8 The -- I'm not going to go into all the
9 details, but as part of the plan we have --
10 (Inaudible) applies to everything on the project
11 and -- and it includes -- we were talking before
12 about confidentiality and security provisions, as
13 part of the quality plan also mentions that --
14 what we have to do to comply with the -- with any
15 security or confidentiality provisions. It also
16 outlines the organization, who does what. And in
17 the SC&A organization, further down, which person
18 does what, what -- what the different functions
19 are so you work together. This is like project
20 management 101 a little bit, but who's
21 responsible for different things.

22 The -- it ensures also that all work's done
23 to -- according to approved procedures, and we're
24 talking about approving procedures and that the
25 right people have the right procedures, and that

1 they acknowledge they have the procedures and
2 they're up to date with the latest procedures.

3 And these are the -- altogether right now we
4 have five procedures listed on this page. We
5 were talking earlier -- Joe -- something about
6 the site profile review procedure, that's one of
7 them, so all work is done according to the
8 approved procedure that we wrote and the Board
9 approved. In part of the QA process we make sure
10 that if Joe has ten people on his staff doing
11 site reviews that all of them have the procedure
12 and they acknowledge receipt and understanding of
13 it, and they have the latest copy of the
14 procedure.

15 It also outlines the management process about
16 how we manage the project. This is the task
17 order process, how we receive task orders from
18 the Board and we respond with task order
19 proposals and manage the -- you know, the budget,
20 the -- the time and the work product.

21 I mentioned the training and documentation.
22 Everyone has to basically sign off on the QA plan
23 in the project. And the final -- we have a QA
24 file also at our headquarters in the same NIOSH
25 file room. It's a secure file. And that's

1 available for inspection -- proper inspection
2 also at any -- any time the Board would choose to
3 do so. Thank you.

4 DR. ZIEMER: Thank you very much. The
5 quality assurance plan also is a deliverable to
6 this Board and will require a similar action.
7 This is not the plan. This is a summary of the
8 plan, so we have the same issue on hard copy
9 here. And are there -- do you anticipate any
10 modifications to the actual plan before we take
11 action?

12 DR. OSTROW: No, I -- I didn't have anything
13 other than there's a typo here or there, maybe,
14 but I -- which I don't think there is, though.

15 DR. ZIEMER: No, okay. Let's open the floor
16 for questions. Tony?

17 DR. ANDRADE: Steve, your last bullet said
18 that you had a section in there on problem
19 resolution.

20 DR. OSTROW: Yes.

21 DR. ANDRADE: I read -- I read the QA plan a
22 few days ago, but I must admit it's getting a
23 little hazy now. Does that include a section on
24 -- on problems that could exist between the Board
25 and SC&A? For example, the one that was

1 described at the very beginning, you know, that
2 we may have to change tasks or change the scopes
3 of tasks as -- as time goes on.

4 DR. OSTROW: It deals with problems between
5 the Board and SC&A, but I'd have to reread that
6 myself in more detail to see exactly what the
7 extent is of the -- how much detail we went into
8 in the plan --

9 DR. ANDRADE: Okay.

10 DR. OSTROW: -- to see if it covers a
11 situation like that.

12 DR. ZIEMER: Other questions at this point?

13 (No responses)

14 DR. ZIEMER: Okay. Again, we'll defer action
15 on this for -- temporarily till we are sure that
16 everybody has a hard copy and we have that before
17 us for action, which probably is going to be
18 tomorrow's work session, based on where we are on
19 our agenda right now. Thank you very much.

20 DR. OSTROW: Thank you.

21 DR. ZIEMER: Can we take a very quick break?

22 Let's take ten minutes and then we'll hear from
23 Jim, which will be the last item on our agenda
24 for today.

25 (Whereupon, a recess was taken.)

1 SITE PROFILE STATUS AND DATABASE USE

2 DR. ZIEMER: We're set for the last
3 presentation, and that will be a report on the
4 site profile status and database use, by Jim
5 Neton. Jim, you're set to go?

6 DR. NETON: (Off microphone) Yes.

7 UNIDENTIFIED: Too much going on. Too much
8 going on.

9 (Pause)

10 DR. NETON: (Off microphone) Thank you.
11 (Inaudible)?

12 DR. ZIEMER: I think you may have to click
13 the button, Jim.

14 DR. NETON: Got to be a little closer --
15 there we go. Is that better? Okay, thank you.
16 Let me have a chance to catch my breath here. I
17 was trying to juggle several tasks at the same
18 time, which seems to coincide with my new
19 position.

20 DR. MELIUS: We need more water here.

21 DR. NETON: I'm here to present what's sort
22 of become a standard presentation as of late,
23 which is to talk about the site profile status,
24 where we are and where we're going with those
25 documents. As well as -- there usually seems to

1 be a little twist on that, there's a little extra
2 kicker that goes along with the presentation.
3 And today I'd like to address what the Board
4 asked about last time, which is a little
5 description of the database; more specifically,
6 the site research database. And concomitant,
7 what goes along with that, is I'd like to touch
8 on a fairly exciting area that we're delving
9 into, both feet first, which is the coworker
10 database and the analysis of claims using
11 coworker data.

12 Okay. As far as the site profiles go, if the
13 Board remembers, we had 16 profiles that were
14 targeted for priority treatment for DOE
15 facilities. The idea behind that was, we picked
16 -- ORAU and us -- ORAU and OCAS together picked
17 the sites that had the highest number of cases.
18 And once we completed those 16 site profiles, we
19 would have data available to begin processing
20 approximately 80 percent of the claimant
21 population base at -- at that time. And that's
22 been holding fairly steady, even since -- for the
23 last year.

24 I'm pleased to report that we have nine
25 complete site profiles at this point, which

1 represent almost 10,000 cases. That would --
2 that comprises roughly 60 percent of our claimant
3 population base. The two asterisks that you see
4 on this slide indicate the two profiles that have
5 been completed since the last Board meeting.
6 That would be the Oak Ridge X-10 facility, which
7 has 1,126 claims, and the INEEL facility with 669
8 claims in our possession.

9 I would remind the Board and the public that
10 a site profile is, in most cases, a compendium of
11 six chapters. Each chapter represents a specific
12 aspect of the site, ranging from the site
13 description to internal dosimetry, external,
14 medical, those types of topics. So when we say a
15 profile is completed, we mean that all six of
16 those chapters have been reviewed and signed off
17 by our office.

18 I will also remind the Board, though, that
19 for expediency purposes we issue some chapters
20 with sections that are labeled reserved or where
21 information is missing, the idea being that if it
22 is substantially complete we will approve it so
23 that we can start processing claims that only
24 require that portion of the data that we have at
25 hand.

1 The next slide I men-- there were nine on
2 that page. There are seven here listed. These
3 are the seven remaining profiles out of the 16
4 that we targeted for completion. And this slide
5 actually shows the individual chapters and where
6 -- what the status is of those chapters, a green
7 box meaning it's green, good to go, it's been
8 signed off by OCAS and is in field use. The blue
9 boxes are those that are in comment resolution.
10 All chapters have at least one draft completed.
11 There -- as I mentioned previously, there is a
12 fair amount of give and take between us and ORAU
13 in the completion of these chapters. And in fact
14 I think since I put this in my presentation,
15 Paducah section four is now complete, so the
16 occupational environmental dose section has been
17 signed off by OCAS, so there actually remains 16
18 out of -- out of 72 chapters, if you will, that
19 are -- that would need to be completed. Which
20 indicates that we've completed about 70 percent -
21 - 77 percent, almost 80 percent of the individual
22 chapters of those 16 site profiles that we had
23 targeted.

24 One might wonder what's the holdup with these
25 that are marked blue. A number of reasons. I

1 think you'll notice fairly readily that K-25,
2 Paducah and Portsmouth are gaseous diffusion
3 plants that are SEC sites by definition. Those
4 are problematic sites. They were granted SEC
5 status because of some issues of transuranic
6 contaminations, among other things. We are
7 taking our time and being very careful to turn
8 over as many stones as we can so that we have a
9 fairly accurate portrayal of those sites.

10 In addition to that, most of the cancers that
11 we'll be getting from those sites are skin
12 cancers and prostate. Skin cancer reconstruction
13 -- skin dose reconstruction can be problematic at
14 some of these facilities. We want to make sure
15 we have certain factors like the geometry and
16 those sort of things nailed down.

17 The other remaining sites that are not SEC
18 sites -- Mound tends to be a compendium of the
19 periodic table of isotopes. If any of you are
20 familiar with Mound, they did a lot of plutonium
21 work, but there's also a large number of legacy
22 isotopes out there that require -- required to be
23 fleshed out.

24 And then you've got some national security
25 sites -- Los Alamos, Pantex possibly -- where

1 we're -- we're still digging for documents and
2 making sure that we've got a fairly accurate
3 portrayal given that some of the information
4 there is -- is classified.

5 Okay. AWE site profiles -- a slightly
6 different story. Did I skip a slide or two? No?

7 DR. ZIEMER: This is the next one in the
8 book.

9 DR. NETON: Okay. These are additional DOE
10 sites that are under development -- nine extra
11 sites that we're working on. These are outside
12 the original 16 we had targeted. I think I
13 reported on these. They are in development. The
14 two that are added to the list that had not yet
15 been listed as under development since the last
16 Board meeting are the two Argonne facilities, the
17 one in -- near Chicago and the one -- actually
18 Argonne West here in Idaho.

19 AWE site profiles, there's been no movement
20 in approved site profiles. We've issued four --
21 Bethlehem Steel, Blockson, AWE complex-wide and
22 TVA Muscle Shoals. The Bethlehem Steel profile
23 we have used to complete the overwhelming
24 majority of the cases that were in our
25 possession. They moved through the process

1 nicely. Sanford Cohen & Associates is, as you
2 heard earlier today, is well under way of
3 assessment or an audit of that profile, and we
4 look forward to hearing the results of their
5 findings within -- well, certainly it sounds like
6 before the next Board meeting.

7 I'd like to say a little bit about the AWE
8 complex-wide. We've done a fair number of cases
9 with this profile. Just to remind the Board what
10 this is, we have developed some generic --
11 generic's probably not a good choice of words --
12 some overestimates, what we believe to be
13 overestimates for certain processes at AWEs that
14 used uranium. And in particular they're
15 overestimates for organs that don't concentrate
16 uranium, what we call non-metabolic organs, so
17 cancers of the pancreas, of the bladder or the
18 prostate, those type cancers. And we're fairly
19 confident that with these overestimating doses we
20 assign that we have covered the range of
21 exposures at those facilities. And these -- this
22 has been fairly successful in freeing up a number
23 of claims, particularly at those AWEs where we
24 don't have any profile completed.

25 These are additional AWE profiles under

1 development. There's 20 additional sites listed
2 here. We talked a little bit last time about the
3 point of diminishing returns with development of
4 site profiles. I believe -- I'm fairly confident
5 in saying that it's unlikely that we're going to
6 add many more individual site profile documents
7 to this list. I think if you go through the list
8 of cases that we have in our possession, we're
9 down to 40 or below. Once you get below that
10 target line, it's our opinion that it's really
11 not worth going down and writing a specific
12 document. We prefer to either modify an existing
13 document to accommodate the unique nature of that
14 AWE, or simply write a larger dose reconstruction
15 report that includes all the relevant
16 information. And the fact of the matter is
17 that's why we have site profiles, so we don't
18 have to publish 80-page dose reconstruction
19 reports. I mean the profile can be referenced
20 and people can get it on the web site. But for
21 these smaller -- what I call mom and pop AWEs --
22 I mean we have five or six claims that were
23 little machine shops out in the hinterlands.
24 We'll probably adopt that kind of approach just
25 to include the entire explanation in the dose

1 reconstruction report. Might make the report a
2 little less readable, but it would probably be
3 more time-efficient for our purposes.

4 I'd like to talk a little bit about the
5 worker outreach meetings. That's been, I think,
6 a pretty good success story. Bill Murray, some
7 of you may know, heads that up for us in ORAU's
8 organization, but we work very closely with him.

9 In fact we've had a NIOSH representative at each
10 of these meetings. We feel it's important to
11 have our staff and our position covered there.

12 We've had 13 meetings since we had the
13 original one in Savannah River in 2003. And
14 you'll notice that we've had multiple meetings --
15 there seems to be a pattern emerging where we're
16 going back to some sites. This has principally
17 been at the request of either the work force or
18 just -- we had a feeling at these meetings that
19 there was some information that we didn't
20 capture. So we've actually had three meetings at
21 Hanford, two at Portsmouth and, you know, we're
22 considering wherever it's possible -- INEEL may
23 end up having an additional meeting.

24 It depends, but when you go to the site, you
25 work with the union reps, construction trade

1 folks, oftentimes you'll hear much more from them
2 than you can capture in an individual setting.
3 And particularly in the way the meeting is
4 formatted, which is almost sort of a town hall --
5 mini town hall format. When we go back we've
6 adopted sort of a workshop format where we'll sit
7 around a round table and try to elicit from the
8 folks any additional concerns they might have.

9 I would remind folks that we do take meetings
10 of all of these minutes -- or minutes of all
11 these meetings, excuse me. And as they are
12 approved, we send them to the attendees to make
13 sure that they're factually accurate. Once those
14 have been vetted, they will appear or do appear
15 on our web site.

16 All right, let me get into the site research
17 database a little bit. This was brought up at
18 the last Board meeting that -- you know, what is
19 this site research database. And I think in
20 particular it was -- it was brought up more in
21 the context of where are these incident files
22 that you guys have been talking about. So I'd
23 like to just take a step backwards and talk about
24 the site research database first, what it's
25 intended to be. And you heard -- I believe it

1 was Joe Fitzgerald just mention that I think they
2 had a training session within the last few days
3 on this. This is the database that we are
4 providing access to Sanford Cohen & Associates.
5 This is our entire database of all the records
6 that we have captured from the inception of this
7 project.

8 It doesn't mean all the records that may be
9 out there because some of the records that are in
10 the public domain we just haven't bothered to put
11 on there, and we can do that and we will do that.

12 But these are the data capture efforts where
13 we'll go out to a site and we'll bring them in,
14 scan them and put them into this database. This
15 contains images and data files for -- it's
16 intended to contain images and data files for all
17 covered facilities. I don't know that we
18 actually have a populated image for each of the
19 215 facilities or whatever we have claims for.
20 But wherever we have captured them, if they fit
21 into one of these 215 pigeonholes, that's where
22 they go.

23 So it's organized by facility, so if one
24 wants to look at all the records we've captured
25 for Hanford, you can do that. This is a SQL

1 server database that is linked in the whole NOCTS
2 scheme of things, and it has -- it's recently
3 developed a very nice front end -- what we call
4 front end or an application interfa-- user
5 interface so that it has keyword searches
6 available, all kinds of nifty things that people
7 who do this type of work like to have to be able
8 to expedite their work. Frankly, when it was
9 originated it was on our network drive. It was
10 the O drive and it was just a bunch of files
11 listed by facility. Now it's much more user-
12 friendly and -- and, you know, more efficient for
13 us to be able to do work.

14 What happens is when data capture efforts go
15 out, there is -- there is a standard form. It's
16 a yellow form, two-sided, that are -- is required
17 to be filled out for each file that is captured
18 out in the field. These files are indexed by
19 keywords. They are indexed and reviewed by
20 someone somewhat knowledgeable about the
21 operations of facilities, and a little mini-
22 abstract is prepared that kind of tells you what
23 the content of that file relates to, and also the
24 time frame and -- sort of the key parameters that
25 you might want to know about this file rather

1 than waste your time having to read through the
2 whole contents.

3 There's almost 10,000 references out there --
4 reference documents, as they call them -- that
5 represent almost 45,000 files. I tried to get a
6 page count because I know -- I relate more to
7 page counts, and it wasn't easy for them to give
8 me that, but I think anybody who does anything
9 with computers will recognize that 65 gigabytes
10 of data is a fair -- fairly large database. It's
11 fairly robust.

12 Of course the larger sites have more files.
13 If you go out there and look at the Savannah
14 River Site, I think you'll find 380 files out
15 there or something like that, and it varies from
16 there.

17 Just one thing I'd like to point out is this
18 was originally intended to be the research
19 database that was used, and it was used, for site
20 profile development. But it has also since
21 morphed, if I can use that term, into a database
22 that contains key links to capture coworker data.

23 It kind of takes me into my next phase of
24 presentation.

25 In capturing these data files -- in the

1 beginning they were just raw captured and put
2 into these bins because, you know, we're just
3 trying to collect these informa-- then it became
4 fairly obvious that many of these files had
5 information that could be used for coworkers --
6 bioassay monitoring data, TLD results, air sample
7 -- you know, whatever type of information there
8 was. The database now is being linked so that
9 when information is available that could be used
10 in dose reconstructions, there is a link
11 established -- and in fact if there is unique
12 data for a claimant, there is a link established
13 to that claimant to alert the dose reconstructor
14 that there is information in the site research
15 database that could be used to process that dose
16 reconstruction.

17 That effort is nowhere near complete, but
18 it's ongoing and they're fairly -- they're well
19 into it, but it's not -- it's not as complete as
20 we'd like it.

21 Since I broached the subject of coworker
22 data, I'll delve into it. Coworker data exists
23 in the database here, which is the captured
24 images that we've -- we've got in our data
25 capture efforts at the various facilities. But

1 there also is claimant data that can be used as
2 coworker data. That data is also being keyed in
3 to the database -- the worker profile database,
4 if you will -- so you have a combination of
5 captured data that may be the universe of
6 monitored people at a facility, but -- or pieces
7 of that facility. Then you also have keyed in
8 information. The 16,000 responses we've received
9 from DOE that has external monitoring data is
10 actually keyed in at the Richland office of Dade
11 Moeller. So that information then is also become
12 -- becomes available to reconstruct coworker --
13 coworker data.

14 We've spent a lot of time in the beginning of
15 this project -- and frankly, most of the first
16 4,000 claims that we reconstructed relied
17 predominantly on individual monitoring data --
18 external badge results, urine samples. People
19 who were -- I don't want to necessarily
20 characterize it well-monitored, but were
21 monitored and characterized some way in their
22 work environment using personal samples. The
23 site profiles speak to that almost exclusively.
24 There is some coworker data in some of the site
25 profiles, but by and large the site profiles that

1 exist today speak very directly to interpretation
2 of individual monitoring data and the exposure
3 conditions at the facility.

4 We are now at the point where coworker data -
5 - we've done a lot of the claims -- I don't want
6 to say we're done with that, but we're working
7 through those and now we are poised to develop
8 the coworker database for people who were not
9 monitored at all, or very poorly monitored and we
10 need to supplement their data files.

11 So we're going to use the data from the
12 capture efforts that we took out there at these
13 sites, and the individual monitoring data from
14 the workers, and there's a couple other sources
15 of information here that I'll talk about. The
16 Oak Ridge Associated Universities Center for
17 Epidemiologic Research database; there have been
18 a large number of epidemiologic studies done in
19 the past evaluating workers at these facilities.

20 These epi studies have catalogued a large
21 portion of the available records. I'm not saying
22 they're perfect, but we need to take -- I think
23 we should look at them. We are looking at them
24 to make sure that we take full advantage of those
25 efforts.

1 In addition to that, we also have -- I
2 mentioned the claimant data -- the Health-related
3 Energy Research Branch within NIOSH also has
4 conducted a number of epi studies, and there is
5 coworker data for them. To some extent that
6 overlaps with what the Center for Epidemiologic
7 Research holdings have, but there are some unique
8 facilities that the HERB database has. INEEL
9 happens to be one of those.

10 And then lastly there is the CEDR database,
11 the Comprehensive Epidemiologic Data Resource is
12 actually a DOE-funded activity where all -- not
13 all -- epidemiologic studies, as they are
14 published, the de-identified data, the stripped
15 data of personal identifier information, is put
16 out onto a facility -- by and large accessible to
17 the public, with some minor restrictions -- for
18 use in further analysis and epi studies. And
19 there may be some use that we can put to that
20 dataset.

21 So this is the compendium of information that
22 we intend to be looking at or ORAU is looking at
23 to develop these coworker datasets.

24 Y-12 facility is actually our first completed
25 profile for external dose using coworker data for

1 the '51 to '65 time frame. Actually it's
2 complete. We haven't -- OCAS has not signed off
3 on it yet as of yesterday, I don't think, but --
4 but we're that close. I mean we've gone round
5 and round and I expect that that will be issued
6 within the next few days.

7 So what are we going to do with all this
8 data? We've got these datasets out there of
9 monitoring information. They're going to take
10 these sets and develop external -- for external
11 dosimetry we're going to develop dose
12 distributions for time periods for work-- when
13 workers were not monitored, or even for when
14 workers were monitored, workers that were not
15 monitored. We can develop these distributions.

16 We're going to pay attention, though, to job
17 categories as they are available. I mean clearly
18 the best coworker data would be a perfect match
19 for a chemical operator who worked in 1956 in
20 plant two with a chemical operator side-by-side,
21 that would be idea. That's unlikely to happen in
22 very many cases, so we have to come up with some
23 sort of a distribution that describes what is the
24 reasonable characteristic exposure of these
25 folks, and then put some uncertainty bounds about

1 them to allow for the fact that we really are not
2 100 percent certain what their exposures were.
3 By and large these will end up -- those of you
4 who are statistically oriented -- lognormal
5 distributions. Most occupational exposure data
6 tends to be that. We'll be evaluating these as
7 we go.

8 Internal bioassay data is a sort of a unique
9 set. We have a lot of -- as I'll show you later,
10 some of the volume of data that's out there --
11 internal bioassay, that is urine samples, are not
12 directly informative of what the exposure was
13 because those are unique to the person and time
14 and place of where they worked and how long they
15 were exposed. But what they can tell us is give
16 us an estimate of what the effective air
17 concentration was in those work areas. So if we
18 have a whole population of workers, let's say we
19 have 5,000 air samp-- 5,000 bioassay samples for
20 a work force over a three-month period. We
21 should be able, using that data, to establish at
22 least let's say the maximum conditions of
23 exposure that existed in that facility, because
24 we have a lot of urine data. And where we don't
25 know process information -- solubility type,

1 particle size -- if we make some fairly claimant-
2 favorable assumptions, then we'll at least be
3 able to put some bracketing conditions about
4 those exposure scenarios. That's the plan.

5 This is -- this is actually a fairly exciting
6 area of investigation. I'm not aware of anybody
7 that's actually kind of done this before at this
8 level of magnitude.

9 I have one additional point here, though. As
10 with dose reconstructions, a standard hierarchy
11 of datasets is employed. That is, you know,
12 personnel monitoring data would be our -- not a
13 gold standard, but our best indication of the
14 workplace exposure, followed by area monitors --
15 you know, TLDs that are hung about the buildings
16 -- followed by the air samples, that sort of
17 hierarchical approach that we use for dose
18 reconstructions.

19 This just -- I'm just going to go through a
20 few slides here to give the Board a sense of the
21 magnitude of the data that may be out there. And
22 this is above and beyond the 16,000 sets of data
23 that we have from the claimant population that
24 we've received from the Department of Energy. Of
25 course there may be some overlaps here, as well.

1 These are the holdings that the Center for
2 Epidemiologic Research at Oak Ridge Associated
3 Universities has. I've got two slides here. I
4 just did a rough addition. We -- there's over
5 4,000,000 records of bioassay monitoring results
6 in the possession of Oak Ridge Associated
7 Universities. So for example at the Y-12
8 facility, external dose -- that's TLD, film badge
9 measurements, there is -- this is all
10 computerized already. This is not going back and
11 pulling stuff out of files. There are 834,000
12 TLD film badge results. There's a million urine
13 samples from the X-10 facility in ORAU's
14 possession on a computer database right now.
15 Again, I can go through the litany, but you know
16 -- external dosimetry, 330,000 -- 329,000 at K-
17 25; 671,000 urine samples. There's whole body
18 counting information, which if we can -- we can
19 determine to be an accurate estimate of course is
20 a very good indication of what the workers
21 actually were accumulating over the long haul.
22 Insoluble material over a long work period tends
23 to accumulate in the lungs, so if we have, you
24 know, 100,000 whole body counts at Y-12 -- is
25 that right? Yeah -- we should be able to come up

1 with some sort of estimate of the upper limits of
2 exposure.

3 And by the way, these values go back to the
4 earliest days of operation of the facilities --
5 1950's, 1945, that sort of thing.

6 Here again is the last four sites that we
7 have computerized information at ORAU. Savannah
8 River Site, almost 30,000. Mallinckrodt's sort
9 of an interesting mix of information. Much of
10 this was already discussed in our site profile,
11 but some stuff that people might not be too
12 familiar with, there's almost 2,400 breath radon
13 samples. Breath radon analysis was an
14 interesting technique -- not sure it's used too
15 much anymore, but if you breathe in radium,
16 radium eventually decays to radon gas, and so you
17 will be -- if you have a significant body burden
18 of radium, you will constantly be breathing out
19 radon gas. So it's an indirect measurement. If
20 you breathe how much radon gas is in a person's
21 breath, you can infer how much radium is in their
22 body. So given the pitchblende ore that was at
23 Mallinckrodt, there was some concern at that time
24 of what the radium burdens were, so we have
25 breath analyses for that facility -- 5,000 radon

1 air sample measurements. So a lot of good data
2 out there, already in computerized form.

3 Of course all this data -- these data need to
4 be vetted and validated to make sure that the
5 monitoring technique used gives the -- we have to
6 give the values some sort of credibility. We
7 just can't blindly use these datapoints. That's
8 understood and recognized by us.

9 This is the CEDR resource holdings I
10 mentioned. That's the DOE-funded cite that's out
11 there for the public to use. And not quite as
12 many, not quite as rich a dataset, but they are
13 out there. There is some overlap. A couple of
14 interesting ones that weren't there -- LANL-Zia,
15 maybe, and -- this is the United States
16 transuranic registry where people can -- workers
17 can donate their body to science at the end of
18 their lives and they can either do a whole body
19 donation or a tissue. There are tissue analyses
20 stored here that can be used to evaluate
21 exposures.

22 Now I mentioned that when we -- when ORAU,
23 for the most part, goes out and does data capture
24 efforts, they do find individual monitoring data
25 from various sites. And this is just a listing

1 of the individual data sheets that were collected
2 from data capture efforts, and this happens to be
3 facilities where we've retrieved film badge or
4 TLD measurements, estimates of external dose.
5 These range from fairly large holdings all the
6 way down to small numbers of measurements at some
7 of these smaller facilities. By and large, a lot
8 of the smaller facilities -- early on these --
9 these film badge measurements were done by the
10 Health and Safety Laboratory of the Department of
11 Energy as part of the AEC back then. And we have
12 some pretty good records, including the original
13 calibration measurements that were done. So
14 these, again, are another source of information
15 for coworker data.

16 These are sites where there were actually
17 bioassay data that were captured in these files,
18 so we do have some. Again, these tend -- a lot
19 of these tend to be AWE type uranium facilities -
20 - Chapman Valve, Hooker Chemical, Ajax
21 Magnathermic -- a lot of these just AWEs. Mound
22 facility is interesting. There's a fair amount
23 of polonium data hanging out there.

24 Okay. That's all of what I (Inaudible)
25 wanted to cover on the coworker data. If there's

1 any questions or comments, I'd be more than happy
2 to talk about them.

3 DR. ZIEMER: Dr. Melius.

4 DR. MELIUS: Yeah, I have a few questions.
5 The -- I think I was the one that originally
6 brought some of these issues up regarding this --
7 this database, and so refresh my memory 'cause I
8 -- was a few meetings ago and so forth, but my
9 understanding was that the site profile documents
10 don't necessarily reference everything that you
11 have in the database. Is that -- and...

12 DR. NETON: That's true. That's true.

13 DR. MELIUS: Yeah. So would an individual
14 dose reconstruction that was -- would -- I assume
15 it would reference the database -- it would
16 reference the site profile -- you know, worker X
17 someplace -- and then would also -- if one of
18 these documents were used in their dose
19 reconstruction, would it reference it in the dose
20 reconstruction?

21 DR. NETON: Yeah. Yeah, that's a good point.

22 The Y-12 criticality incident is a very good
23 example of that. We have a Y-12 document. It
24 may mention the criticality accident, but it's
25 not going to go into any elaborate detail because

1 there's an entire report. And the six or so that
2 we've done, we have referenced the individual
3 report. That's a good example. I can't think of
4 other instances, but...

5 DR. MELIUS: Would it be helpful in terms of
6 the transparency of the program and maybe dealing
7 with some of these issues regarding questions
8 people have about their individual dose
9 reconstructions to have some sort of public
10 access to a listing of what documents are
11 available, or maybe the short abstract of that --
12 along with that short abstract of that document
13 available to --

14 DR. NETON: Yeah, I think that's a very good
15 suggestion. We'd talked about that before, I
16 think even.

17 DR. MELIUS: I just seemed to me with some of
18 the issues that Pete Turcic brought up this
19 morning and --

20 DR. NETON: Well --

21 DR. MELIUS: -- the questions people have are
22 well, did you look at everything or --

23 DR. NETON: -- I think abstracting 10,000
24 documents would be difficult, but publishing a
25 list of the documents that are contained on the

1 web site certainly would --

2 DR. MELIUS: I thought you already had a
3 brief abstract --

4 DR. NETON: Well, you're right, there are --

5 DR. MELIUS: -- from your description. I'm
6 not asking you to do extra work. I was just
7 thinking of would it be helpful --

8 MR. ELLIOTT: I don't see it as extra work.
9 The dose reconstruction report provides the
10 reference. If the individual claimant or
11 claimants want to see that reference in its
12 entirety, they're entitled to it. We provide it
13 --

14 DR. MELIUS: Uh-huh.

15 MR. ELLIOTT: -- upon request. If they want
16 to see the abstract, we'd provide the abstract.
17 If they want to see the whole document, we
18 provide the document. They can do that either
19 by, you know, requesting it of us through the
20 closeout interview process, by e-mail, by a
21 telephone call, or if they want to come into the
22 offices we have a public reading room that they
23 can view those things from.

24 DR. NETON: I agree with that. I don't think
25 putting out a listing of what's on the web site

1 would be that -- that large of a challenge. And
2 frankly, we -- I talk to claimants a fair amount,
3 and some of the con-- people call up and say are
4 you aware of this document -- it may be easier if
5 they could access the web just to see that we had
6 it and we've already covered it.

7 DR. MELIUS: Yeah.

8 DR. NETON: A lot of these documents that
9 people think are super-relevant may or may not
10 be, it depends on --

11 DR. MELIUS: No, and there's a danger it
12 could sort of lead to extra work. People think a
13 document should have been used and it isn't. But
14 one would presume that you would have already --
15 you know, when you do the dose reconstruction,
16 that would have -- you know, if somebody
17 (Inaudible) bit knowledgeable about that, so I
18 just think it would help --

19 DR. NETON: Sure.

20 DR. MELIUS: -- sort of people understand all
21 the work that you're doing on the program.

22 Second question I had was -- I think at the
23 last meeting or the meeting before you brought up
24 that you were working on the construction worker
25 aspect of the site profiles. Where does that

1 stand and how is it affecting the processing of
2 those claims?

3 DR. NETON: We continue to work on the
4 construction worker profile, although admittedly
5 much more slowly than we'd like. We are having a
6 meeting in August at the Savannah River Site that
7 has been organized by some folks -- Knut Ringen
8 is involved in that -- where we're going to meet
9 with construction workers. One of the issues
10 we're having is just trying to get access to some
11 construction workers to work with us a little bit
12 on these issues so that we really do capture the
13 unique exposure characteristics. And it's slower
14 getting us together than we'd like. We have not
15 made a lot of progress. And the reality of that
16 is that that is delaying completion of
17 construction worker claims -- not all
18 construction worker claims. We feel in some
19 cases with construction workers with certain
20 circumstances that we may be able to complete
21 them using either some maximizing assumptions --
22 if they were in facilities where we feel
23 comfortable with the exposure characteristics,
24 we'll do that.

25 DR. MELIUS: Yeah, it's just that -- I mean

1 it's just very hard to evaluate that until you've
2 looked at the other, and what's going to be in
3 this site -- construction worker site profile.

4 DR. NETON: Right. I think I fleshed out the
5 last Board meeting that general topics are going
6 to be covered, but reality is we have not gone
7 very far.

8 DR. MELIUS: Third is more of a technical
9 question. It may be something for a future
10 presentation, but to me, with this issue with the
11 coworker data is -- a lot of the issue is sort of
12 what uncertainty do you assign to that
13 extrapolation or the use of that thing. And if I
14 recall right, I think it was in Rocky Flats we
15 had some testimony about -- at least in some of
16 the processes there, I think it was some of the
17 plutonium exposures, where coworker data wasn't a
18 very good predictor or -- of -- you know, two
19 people doing similar processes standing side by
20 side or close to each other, it was not, so --

21 DR. NETON: That's a good point. I think
22 very rarely would we use side-by-side exposures.
23 We would tend to use a distribution.

24 DR. MELIUS: Right.

25 DR. NETON: And I'm going to talk a little

1 bit about that tomorrow, how we're assigning
2 uncertainty to some of these things. You know,
3 we try to craft the distribution and it'd be nice
4 to match job categories, job titles. Reality is
5 that we don't have that for many of the
6 claimants. Then we end up developing these
7 larger distributions where we put in a fair
8 amount of uncertainty to accom-- we believe, to
9 accommodate the lack of knowledge -- our lack of
10 knowledge.

11 DR. MELIUS: My final question's on the site
12 meetings that you're holding. Have you thought
13 about holding any of these meetings earlier on in
14 the process?

15 DR. NETON: Yes.

16 DR. MELIUS: I guess I think -- particularly
17 the Linde site, where there was a fair amount of
18 comment up at the Buffalo meeting that --

19 DR. NETON: Yes, that's a good point. We
20 actually end up sort of tailoring when we visit
21 the site based on the individual needs. Some
22 sites want us to come later in the process.
23 They'd like to have a document that they've
24 reviewed and they can comment on it. It's easier
25 to form comments if you've got something to read.

1 Some sites would rather have us come in at the
2 very front, and Linde I think is probably a good
3 example of that, that would like us to come there
4 and capture their story before we go too far down
5 the line. So it really varies depending on the
6 site.

7 DR. ZIEMER: Thank you. Roy?

8 DR. DEHART: Perhaps you could remind us
9 about how you take the recommendations, the
10 concerns from the various sites and incorporate
11 into the site profile. For example, while we
12 were at Hanford there was considerable
13 discussion, and this was followed by a letter --
14 a multi-page letter from one of the union
15 activities. How do you use those concerns
16 expressed in that letter in looking over the site
17 profile, adapting it if necessary?

18 DR. NETON: Several ways we do that. In the
19 cases where organized labor folks would provide
20 us a fairly detailed document, that is passed
21 over directly to the site profile team for
22 evaluation and possible use in modification of
23 the profile itself. Again, these are living
24 documents, we like to say, where the book is
25 never closed. If there's something there that

1 really casts doubt on what we've done and the
2 generosity that we thought we put in there, we'll
3 put it in.

4 So for instance, the Hanford site that you
5 mentioned -- is it Ed Skolsky* I think, Dick --
6 help me out, Ed Skolsky is Hanford or no? Well,
7 no, he's -- he's not -- we -- we fed that through
8 the loop and they're actively -- there's been
9 meetings held on these issues and we will get
10 them back into the profile, and also feed back to
11 the people that originated the document what --
12 what we found. When we post these minutes, we
13 also want to get back to the workers -- you know,
14 when we have verbal comments, even -- so we've
15 constructed a database. There's a database that
16 exists now of all the concerns that we've
17 captured at all the meetings we've had. So it is
18 out there. We can track and trend common themes,
19 issues, that sort of thing. And we're working
20 hard to address those things.

21 Is it going as fast as we'd like? Probably
22 not, but we haven't forgotten. And I mean Bill
23 Murray at the helm over in ORAU, I know he's a
24 tiger on this. We meet very frequently to figure
25 out how best to address these comments. I don't

1 know what else to say.

2 DR. ZIEMER: Mark?

3 MR. GRIFFON: Jim, I'm just curious, if --
4 along the line with the coworker data, I'm just
5 curious, given our discussions with the case
6 selection process and the variables that you have
7 in the database for your individual claims -- I
8 mean it doesn't seem to me that some of the key
9 variables to linking workers are even being
10 collected in your claims files. So -- so I'm
11 curious how your --

12 DR. NETON: I'm not sure what you --

13 MR. GRIFFON: -- established cowork-- for
14 example, job -- job category. Right now you
15 don't have that as a -- a searchable field.

16 DR. NETON: Right. Yeah, when I was talking
17 about the job categories and stuff, those are --
18 those are typically more present in the
19 epidemiologic databases. I mean you'll -- you
20 know, they go to a great extent in epi studies to
21 -- you know, laborers, you know, administrative
22 folks and that sort of -- that's what I was
23 really referring to.

24 MR. GRIFFON: So you're going to go -- you're
25 going to rely on those?

1 DR. NETON: We're going to rely on those.
2 You're right, though. With the 16,000 that we've
3 had in-house where we've keyed them, we don't
4 have the linkages in place at this point to track
5 those -- those datasets.

6 MR. GRIFFON: And I'm just wondering, even at
7 the -- I mean I don't think you capture anything
8 sort of at the sub-facility levels as far as
9 where they worked within the -- just thinking of
10 the way these things --

11 DR. NETON: Right, they're not -- they're not
12 captured discretely, but you know, these are
13 certainly searchable fields. As you know, doing
14 this kind of work, though, you would have to
15 envision up front some categorization that would
16 work, and there are any number of ways to
17 characterize a facility. Some people call it
18 plant one, some people call it the green salt
19 factory. You know, so to categorize that within
20 our own database is actually more work than we've
21 been willing to take on at this point. I think
22 that's all I can say. Ideally, that would be the
23 best way to go.

24 DR. ZIEMER: Okay. Further questions,
25 comments?

1 (No responses)

2 DR. ZIEMER: Thank you, Jim. Appreciate that
3 input. We're going to recess now for a bit and
4 we'll reconvene this evening at 7:00 p.m. for our
5 public comment session. Thank you very much.

6 (Whereupon, a recess was taken to 7:00 p.m.)

7 INTRODUCTION

8 DR. ZIEMER: Ladies and gentlemen, welcome to
9 the evening session of the Advisory Board on
10 Radiation and Worker Health. This is the public
11 comment portion of today's meeting. We're
12 pleased to have many members of the public here
13 with us this evening.

14 My name is Paul Ziemer. I serve as Chairman
15 of this Board. In a moment I'm going to
16 introduce the other members. I would like to
17 make a couple of announcements.

18 First of all, we ask that everyone in
19 attendance today register your attendance with us
20 in the registration book at the doorway. Many of
21 you have already done that, but this includes
22 everyone -- Board members, government staff
23 people, members of the public. If you would
24 please register your attendance, if you've not
25 already done that.

NANCY LEE & ASSOCIATES

1 Those of you who wish to speak this evening,
2 to address the Board, we ask that you also sign
3 up in the sign-up book. Some have already done
4 this. But if you do wish to speak and haven't
5 already signed in the book, please do that in the
6 next minutes so we have some idea of how many
7 individuals will be speaking this evening.

8 Before we actually open the floor for public
9 comment, I thought it might be useful if I took a
10 few moments to acquaint those of you here in
11 Idaho, those members of the public who may not be
12 as familiar with the operation of this Board, to
13 tell you a little more about what we do so that
14 you don't misunderstand what we are able to do
15 and what we are not able to do. So with that,
16 let me proceed.

17 This particular program that we're involved
18 in actually involves a number of Federal
19 agencies. These are listed here -- the
20 Department of Labor, Department of Health and
21 Human Services, Department of Energy, and of
22 course the Secretaries of each of those are the
23 key people that are -- as well as the Attorney
24 General -- that oversee this particular program,
25 the Energy Employees Occupational Illness

1 Program.

2 This Board, by statute, consists of up to 20
3 members. We actually do not have 20. The full
4 Board is here before you. These individuals have
5 all been appointed by the President of the United
6 States. The statute calls for the membership of
7 this Board to be made up of a variety of people
8 with different backgrounds, as you see indicated
9 here. These are the words from the statute, the
10 representatives from these various groups: the
11 affected workers or their representatives, and
12 others from the scientific and medical
13 communities.

14 Now in addition to my position as the Chair,
15 let me introduce the others. Our Designated
16 Federal Official is Larry Elliott -- and I'll ask
17 each of these -- they have a placard, but if you
18 wonder who's who, here they are, and their titles
19 are indicated here for you to see; Dr. Henry
20 Anderson, Antonio Andrade, Roy DeHart, Richard
21 Espinosa, Michael Gibson, Mark Griffon, James
22 Melius, Wanda Munn, Leon Owens -- Charles -- oh,
23 Leon isn't here; I'm sorry, Charles Leon Owens,
24 who goes by Leon -- Robert Presley and Gen
25 Roessler. So these are the members of the

1 Advisory Board.

2 So what is it that this Board is responsible
3 for? And here is the information, again pretty
4 much quoting from the statutes. We're
5 responsible for advising the Secretary of Health
6 and Human Services, and we are an Advisory Board,
7 and our advice goes to the Secretary of Health
8 and Human Services. And that advice takes three
9 parts, advising on the development of some
10 guidelines -- and those guidelines have been
11 developed. The one guideline has to do with
12 what's called probability of causation, which is
13 the idea of is it more likely than not that a
14 cancer was related to the individual's radiation
15 exposure.

16 And then advising on the guidelines for dose
17 reconstruction. Those guidelines are in place
18 and have been published in the Federal Register.

19 We have some responsibility on evaluating the
20 validity of the dose reconstructions that are
21 being done by NIOSH, and that is a sort of audit
22 function which we have underway.

23 And then finally we are to be involved in the
24 determination of whether or not there are
25 individuals who should be added to what are

1 called -- or what is called the Special Exposure
2 Cohort. There are guidelines on this that were
3 recently published, and there are petitions now
4 that are coming into the system, as it were, on
5 the Special Exposure Cohort. The Board then will
6 review those and have advice on those particular
7 petitions.

8 So that is what the Board is responsible for.

9 We do not do the dose reconstructions. We do
10 not adjudicate the findings. We are not a board
11 of appeals. We -- we do like to get feedback
12 from people. We do like to learn of your
13 experiences insofar as they help us understand
14 how the system is working or not working. And I
15 know many of you -- and our experience has been,
16 as we've talked to groups around the country at
17 various sites, people do have their stories to
18 tell us. And as I say, we don't get involved --
19 the Board does not get involved in your case, but
20 whatever you tell us may help us understand what
21 may be working or not working in the system. So
22 you're welcome to tell us your story -- or any
23 other observations you wish to make.

24 We're not necessarily here to answer
25 questions. We're here to listen. So we are here

1 just to hear what you have to say. If you have
2 questions about your particular claim, if you
3 have a claim, we do have an individual here --
4 Lynda Brandal is here this evening and she is the
5 public health advisor for the program, and Linda
6 is going to be back at the table back there at
7 some point. And if you have specific questions
8 on a claim, she will be the one to direct you to
9 get what information you need.

10 Also, the Department of Labor has a table --
11 many of you saw it when you came in -- near the
12 entrance that has other information about the
13 program that you might find helpful.

14 PUBLIC COMMENT

15 So with that as background, we'll proceed to
16 the public comment portion of the meeting. I'm
17 going to return to my seat and get the list of
18 those that have decided they would like to speak.

19 Now I should also tell you that there are a
20 lot of folks that sort of want to speak, but they
21 don't want to go first. But it's sort of like
22 getting olives out of a jar. You know, the first
23 one -- once you get it out, the rest come pretty
24 easily. So we're going to get the first speaker
25 going, and if you then change your mind, it's not

1 too late. I'll give you the opportunity to
2 speak. Okay?

3 So let me get the list here and see who the
4 first olive is. And I may have a little trouble
5 reading the writing. It looks like Clinton -- is
6 that right, Clinton Jensen -- Johnson -- Jason?
7 Could you approach the mike, sir? And also for
8 the record, indicate -- I believe it says Faith,
9 Idaho or --

10 MR. JENSEN*: Firth.

11 DR. ZIEMER: Firth, Idaho. Thank you.

12 MR. JENSEN: Well -- well, to give you just a
13 little bit of history about myself, I worked at
14 the INEL and I worked at the SMC project, which
15 is depleted uranium. That's all I'll say about
16 that, other than the fact that I burnt -- I
17 incinerated depleted uranium for two -- 18 months
18 and during that period of time I became severely
19 ill and I still suffer with the same symptoms. I
20 had cancer spot removed. There's several
21 different problems that I have. I take morphine
22 and other medicines -- several of them a day --
23 just to get by.

24 DOE hired a doctor out of Bethesda, Maryland
25 -- Dr. Melissa McDermott* -- to come out here and

1 kind of see what she could find out what was
2 going on because I raised employees concerned
3 about the safety and health and the radiation
4 where -- and I'd like to read a couple of things
5 that she found out. And this is -- this was the
6 attitude that SMC had from 1985 till 2002. They
7 -- they had a doctor in charge here in Idaho
8 Falls that never stepped in the area from 1985
9 until after my court in 2002, and he was in
10 charge of the IHS* there. And he never knew what
11 was going on, but yet he was in charge of it. He
12 never had a clearance. He couldn't talk about
13 things -- supposedly. And he never stepped in
14 the area.

15 Her observation of the SMC project, and this
16 was in -- let me -- a date -- this is 2001, but
17 this -- this went on from 1985 when the project
18 started. (Reading) The lack of the on-site
19 experience and industrial hygiene, the SMC IH had
20 neither training nor the experience to carry
21 fully (sic) responsibility for the program. A
22 corporate CIH present for my visit was unable to
23 answer basic questions about the major -- the
24 majority -- major facility hazards and concerns
25 to him. A cookbook mentality of the IH

1 management was observed where complacence with
2 TLD was the only benchmark being used to gauge a
3 potential haz-- health hazards. No truly
4 competent person was identified by me who would
5 have the working knowledge and experience to
6 know, without looking at an MSD, which hazards to
7 expect in a new operation or with the
8 introduction of new things.

9 That's one of her comments on -- on the way
10 that it was run. I had several things happen to
11 me. I had a spill. Management at SMC tried to
12 hide the facts. DOE went in and they found the
13 log of the log book. DOE did a pretty -- pretty
14 fair investigation of what they did investigate.

15 I had several -- different times during the
16 periods of the years, I had spikes in the
17 urinalysis. The urinalysis was not being ran
18 right. That was one of my concerns, too, that
19 urine samples were being lost. The day that I
20 took this one sample supposedly that had spiked
21 at 2.7, I had -- as you know, urinate in a quart
22 jar and they take the jar and they do the
23 samples. I had to cap it off, which probably
24 took about an ounce during that sample in the
25 quart jar. My urine -- or my internal

1 contamination was supposed to be 2.7. I believe
2 that it was higher than that because if you put
3 two ounces in a quart jar and it affects the
4 whole thing or whatever to 2.7, it must be pretty
5 high, in my opinion, from what little bit of
6 chemistry I have that I don't know whether the
7 saturation point or whatever, but it -- it takes
8 quite a bit to raise it to that, as far as I
9 know. And I was made sick at that time on 17th
10 of December, 1998, and my life has been turned
11 upside down.

12 I was called a traitor and everything else.
13 I was pegged as a whistle-blower because of these
14 safety things. They were incinerating this
15 depleted uranium. They were -- only had a permit
16 to construct. They never did pre-sampling. They
17 never did sampling during the thing -- during the
18 operation. These were never carried out. And so
19 it was not an airtight unit. It was not a
20 boughten* one. It was built on-site from -- from
21 sheet metal and angle iron and plexiglas, and it
22 was -- it was -- it was not a safe thing. And as
23 soon as -- as soon as they could, they destroyed
24 it. They got rid of it, so at least nobody else
25 has to do that.

1 This is about all I have to say. If anybody
2 wants to ask me any questions, I'll provide you
3 with my medical record. I filed a claim with you
4 guys. My number's like 10,065 or something. I
5 was advised to wait till my court case was over
6 with in order to file because I did win because I
7 was right and I never lied, and usually the truth
8 prevails. And what I say here is not a lie.

9 This lady, she did down -- down -- she did
10 mark them down in -- in her visit on the way they
11 -- they do business out there, and it wasn't
12 safe, and this was still going on in 2001. So
13 it's kind of like teach an old dog new tricks.
14 They might -- you might think that they are
15 learning, but it takes a long time after that
16 before they ever do, so this is not something
17 that -- that is ancient and stuff. I may have
18 been sick for a long time and still am sick, but
19 like I say, they might have changed now, but
20 during the records and the past, this needed to
21 be brought out that things were not quite kosher.

22 And I can read here where management -- well, I
23 already told you that management tried to cover
24 it up.

25 They did everything they could to silence me.

1 They -- they forced doctors into keeping me off
2 work. They wanted to get rid of me. They had a
3 Army investigation. They tried to lock me up --
4 anything they possibly could to silence me. So
5 I've taken this opportunity, I've taken others,
6 to speak out for those that have been affected
7 like this. I don't think it's right. I don't
8 think it's right that the government can do this
9 to people and get away legally, and managers and
10 can sit there and lie and get out of it, and DOE
11 backs them up by paying their bills and lawyers
12 and everything else. And it's your taxpayers'
13 money that's being wasted by them people frauding
14 (sic) people. So I think that there's a lot of
15 things that have went on that you people will
16 never ever know about unless people like myself
17 will get up and bare their souls to you and tell
18 you some of the things they've been through.

19 So thank you very much for letting me have
20 the time to express myself. Thank you.

21 DR. ZIEMER: Thank you very much. The next
22 speaker will be David Fry. David Fry.

23 MR. FRY: Okay, I just have a couple of
24 questions for the Board. On April 28th we had
25 those site profile meetings here in Idaho Falls.

1 There was one at -- for the building trades
2 people and there was one at PACE union hall, and
3 I'm with PACE. And at that time we didn't have
4 the internal dose report to review. And also at
5 that time we had a lot of current and former
6 employees that were in the room that made
7 comments to the site profiles that we had. And I
8 just wanted to -- and then we received the
9 minutes from that meeting, and I just wanted to
10 ask, will our comments be incorporated into the
11 site profile? Will the site profile be redone
12 or...

13 DR. ZIEMER: Let me ask one of the staff
14 people -- Larry, or Jim Neton perhaps can respond
15 to your specific inquiry.

16 DR. NETON: (Off microphone) Yes, when we
17 receive comments --

18 UNIDENTIFIED: Use the mike.

19 DR. NETON: We receive the comments
20 informally through the organized --

21 MR. FRY: Through the local?

22 DR. NETON: -- local that came there. We
23 have passed them on to the profile team, and they
24 are considering them, at which point if any of
25 them may -- will come to make a difference in the

1 profile that's out there, it will be revised to
2 reflect that information.

3 MR. FRY: Okay, thank you, 'cause the first
4 profile -- there were some critical processes and
5 buildings that we as employees and former
6 employees felt like were missing. And also will
7 there be another meeting in Idaho Falls, another
8 site profile meeting when it's been revised and
9 when the internal dose report's ready?

10 DR. NETON: The internal dose report is
11 completed and it's on -- it's on our web site,
12 available to be reviewed. We are certainly -- we
13 don't have a meeting planned in the near future,
14 but if one were necessary or you felt that you
15 would like to have one, there was enough concern
16 about the information that's out there on our web
17 site, we would be more than happy to discuss --
18 to make arrangements to --

19 MR. FRY: I think the general --

20 DR. NETON: -- conduct a meeting.

21 MR. FRY: -- consensus that day was most
22 people wanted a second meeting, but...

23 DR. NETON: Okay. And I think I mentioned
24 earlier that there was some interest in a second
25 meeting out there, but we just have not yet

1 planned to make that happen.

2 MR. FRY: Okay. That's all I have. Thanks.

3 DR. ZIEMER: Okay. Thank you, David. The
4 next -- Knut Ringen is with the building trades.

5 MR. RINGEN: (Off microphone) Now if you have
6 any other local people who want to speak, I'll be
7 glad to forego my time.

8 Okay, I didn't think so. First of all, I
9 want to thank the Board for holding these evening
10 sessions. I think it was when you had your
11 meeting in Las Vegas that I asked for these
12 sessions, and you've done so since then and I
13 think it's been very useful. And I'd like to
14 make one more request of you today. That is to
15 do a better job of advertising the meetings
16 earlier. For instance, we didn't get notice
17 really of this meeting until about two weeks ago,
18 and didn't have time to notify our members in
19 turn. And I think we -- a better job could be
20 done of advertising them so that -- where we've
21 had more time and been able to prepare -- for
22 instance, for the meeting at Hanford, you know,
23 we had a much, much larger participation, and we
24 would very much encourage you to do that and we
25 would like to help you also in doing that.

1 The main things I wanted to talk about here
2 today are really fourfold. First of all, I think
3 most of us think of this Board as being the
4 conscience of this program, and it's very
5 important that it's -- performs its functions
6 effectively and with support from NIOSH. We have
7 a problem, which I believe stems from a lack of
8 credibility in the overall program, and which has
9 led to a relatively small rate of applications
10 for compensation. Here at Hanford -- no, here at
11 INEL, only about 1,500 workers so far have filed
12 claims out of an estimated, I would guess,
13 roughly 20,000 workers who have been here and who
14 had cancer since they have been here. So that's
15 a very small rate of applications compared to the
16 people who generally should be eligible for
17 compensation. And I ascribe a lot of that lack
18 of response -- and it's something that we see
19 across the complex -- to the low level of
20 credibility that the program has right now. And
21 I don't see any group that can help fix that
22 problem more than this Board can, so your
23 function is very, very important.

24 The second issue I want to bring to your
25 attention very briefly is how data are presented

1 at these meetings and by NIOSH in general. And I
2 think it could be presented somewhat more
3 effectively if you -- obviously you can slice and
4 dice data all kinds of different ways, but if you
5 were to do it in three different ways. First of
6 all, by site, which you do on the web site. But
7 when it's presented here, you don't see any of
8 the data by -- by site, and if you'd known the
9 data by site -- for instances, the data that were
10 presented up through the first quarter of this
11 year were heavily skewed by the results from the
12 Bethlehem Steel facility, and then the last three
13 months it's been heavily skewed by the results
14 that have happened because a large portion of the
15 dose reconstructions that have been done in the
16 last three months have been for Savannah River.
17 And if you just see the results more by site, I
18 think that becomes more readily apparent.

19 The second way that I think it would be
20 incredibly important to see these data -- at
21 least from our point of view -- is by occupation.

22 We would very much like to see a breakout by
23 construction. I think there should also be a
24 breakout by people in production, maintenance,
25 administration and science and technical kind of

1 work. I realize that there are problems in
2 trying to define things by occupation because
3 people move from occupation to occupation. But
4 if you were doing this as an epidemiological
5 study, you'd have to find a way to define a
6 person's principal occupation. There's no reason
7 why you couldn't do it in this case, as well.
8 And if you did present the results by occupation
9 -- the reason it would be interesting to me would
10 be to look at how many construction workers have
11 you done dose reconstructions on so far, and what
12 has the result been, given that there are many
13 problems with the site profiles still when it
14 comes to construction workers, and we have no way
15 of judging that, if you're making lots of dose
16 reconstructions for construction workers in the
17 absence of adequate dose reconstruction
18 materials. We'd like to know more about that.

19 And the third thing that I think would be
20 useful -- and you can argue about this -- is if
21 they could be presented more by probability of
22 causation. And by that I mean there are roughly
23 three groups of workers that we have out here
24 file applications. There are those people --
25 those workers with obviously not enough radiation

1 exposures. Let's say those who have a
2 probability of causation that's less than 20
3 percent. Then there's the group that's obviously
4 compensable. Let's say the people with a
5 probability of causation over 60 percent or
6 whatever it is. And then you have the middle
7 group, the people who cause NIOSH the most work
8 and who lead to the most difficult decisions. It
9 would be very good to see for these different
10 groups how many claims are being filed in each of
11 these categories and what the results are of
12 them. I think that would give us a much better
13 idea about -- is, for instance, the majority of
14 the claims that you're putting through right now
15 the easy claims, and are you leaving out the
16 people in the middle category by and large, and
17 this kind of thing.

18 Finally, I'd like to also say something about
19 the site profiles, and Jim Neton today said that
20 we're working on and we're trying to work
21 together on doing a better job of developing site
22 profiles for the construction workers. And the -
23 - that's been a little cumbersome from
24 everybody's point of view, but I think
25 everybody's trying to work towards that end.

1 But I'd caution you to think about something.
2 Jim referred to site profiles that were
3 completed. And as far as I know, there isn't a
4 single completed site profile. These are works
5 in progress, even though they've been published
6 on your site. And I think maybe saying that --
7 implying that they're complete suggests to me
8 that you're never going to do anything more with
9 them, while in reality you continue to change
10 them periodically -- or may change them
11 periodically, in the sense that you call them
12 living documents. And I would be a little bit
13 more careful with this. And I certainly don't
14 think that you can say that any of them are
15 complete when it comes to information on
16 construction workers at this point in time, and
17 maybe there should even be a caveat in them on
18 that subject.

19 And let me just make finally one more request
20 of you, also, and that has to do with SCA --
21 Sandy Cohen Associates -- review of these site
22 profiles, 'cause they've started to ask if we
23 could organize meetings with workers so that they
24 can go out and interview workers and talk to them
25 about it. And that's a time-consuming and very,

1 very important function, but it's very hard for
2 us to organize a lot of these meetings with
3 workers and provide them with the technical
4 support they need and so on without some funding
5 to pay for the time of these workers, because at
6 least construction workers, if they come to a
7 meeting, they're not going to get paid for that
8 time. So if you will consider, as you look at
9 the contract -- contractor that you have
10 available to you and the scope of work that's in
11 that contract, I would just ask you to consider
12 making available some funding in the -- in the
13 effort to assess the site profiles, or anything
14 else that requires the involvement of the local
15 workers, to provide some reimbursement for those
16 -- for those costs. We don't expect NIOSH staff
17 to work for free. We don't expect DOE staff to
18 work for free. I don't think we should expect
19 workers to do that, either, and I'd like you to
20 take that into account. Thank you for your time.

21 DR. ZIEMER: Thank you for your comments.

22 Now I go to page two, but there's only one page,
23 so do we have a page two?

24 MS. HOMER: No.

25 DR. ZIEMER: There's no page two. Now's the

1 opportunity for anyone who's not signed up that
2 still wishes to addresses the Board. Sir?

3 MR. HANSON: My name is Gaylan Hanson. I
4 work at the INEL. I'm the PACE union health and
5 safety rep. I work closely with retirees, and I
6 have a retiree that, because of illness, was not
7 able to attend tonight. But in a very short
8 note, I'd like to read what he put here. It's a
9 statement. I'll leave his name off. (Reading)
10 Undocumented radiation exposure to worker. In
11 the summer of 1957 I was working for Phillips
12 Petroleum Company as a yardman. I was watering
13 lawns at TRA. I was called to MTR reactor
14 building and told there was a high radiation beam
15 coming from the reactor through an experiment
16 insertion hole. I've heard this many times from
17 other workers of a beam that shot like two miles
18 out toward the highway with a particular
19 experiment they were doing there. They said they
20 couldn't use their operators because they
21 couldn't have them get burned out. I was to go
22 into this sort of tunnel and lay lead brick
23 shielding to stop the beam. I went in, laid two
24 lead brick, came out. They said I had been there
25 too long and was overexposed. I never found out

1 what the exposure was. Another time I was called
2 in to decontaminate the manipulators in the hot
3 cell. I got very contaminated and overexposed
4 there, too. I had no dosimeter or film badge to
5 record dosage levels.

6 And I think this is what a lot of former
7 workers and workers is -- they do a pretty darned
8 good job of documentation of what they have, but
9 what about the unknowns in the area that wore the
10 badges, et cetera? Is there anyone I can leave
11 this letter with? Thank you.

12 DR. ZIEMER: Thank you.

13 MR. ELLIOTT: Thank you, Gaylan.

14 DR. ZIEMER: Yes, and again, have the
15 opportunity for others who wish to comment?

16 UNIDENTIFIED: (Off microphone) You mean
17 (Inaudible)?

18 DR. ZIEMER: Anyone from the public who
19 wishes to comment -- yes, please --

20 UNIDENTIFIED: (Off microphone) (Inaudible)

21 DR. ZIEMER: You'll have to approach the
22 mikes for our recorder to get the information.

23 UNIDENTIFIED: On that same line, there was -
24 -

25 DR. ZIEMER: Would you state -- state your

1 name, please, for the record? Thank you.

2 MR. EGBERT: I'm H. Doyle Egbert. I worked
3 at CPP for 17 years as an operator. But for
4 instance, we had to go into the west vent tunnel,
5 which was a very contaminated area, to roll up
6 lead shielding that covered up a 50-R field.
7 Anybody that worked out at CPP knows what it was
8 all about. It was a nightmare. Another time I
9 had to go into a deep tank, retrieve a camera out
10 of the WG waste tank, which is on the east site,
11 very hot waste that would go to the (Inaudible),
12 50-R fields. They give you two weeks' dosage to
13 go in and do it. You're in there maybe five
14 minutes, but you still are in a 50-R field. And
15 now they won't even think of over a 3-R field, I
16 -- I think, out there now. I could be mistaken
17 on that. They put robots in the cells for those
18 things. But I just wanted to relate that
19 experience that I had and -- and they weren't
20 recorded. I passed out in the vent tunnel. They
21 pulled me out of there, took my respirator off
22 and then I come to on the -- outside the vent
23 tunnel. It wasn't recorded. So just a insight.
24 Thank you folks.

25 DR. ZIEMER: Thank you. Any others?

1 (Pause)

2 MS. CODDING: My name is Shirley Coddington and
3 I was really going to keep quiet till I got to --

4 DR. ZIEMER: Could you spell that for the
5 recorder?

6 MS. CODDING: Oh, C-o-d-d-i-n-g -- and after
7 hearing Knut(you)*, everything he said is
8 absolutely true. The chem plant was known as the
9 garbage dump of the world. It really was. It
10 was dirty. It was a roped area from back of 601
11 just to even walk to an office in the early days.

12 Now granted, everything is a whole lot better
13 now. I think public concern has forced it. But
14 we used to do things that the primary feeling of
15 the chem plant in the sixties and seventies and
16 eighties was do whatever it took to get the job
17 done. And there were a lot of times -- I can
18 tell you many times that my dosimetry badge was
19 not on because we had to get the job done, just
20 throw on the NICs* and get the heck in there and
21 do it.

22 We had a blowout, blew out the bottom of the
23 batch still, and I was one of the three operators
24 that went into the cell. It was right at shift
25 change. Not one of us had a dosimeter on. And

1 even if we did, the INEL did their own recording.

2 They didn't send out for an unbiased opinion.

3 It was unrecorded -- it was unrecorded by a
4 independent. And I don't know of anybody out
5 there that believes what's on their dose is a
6 true reading. There -- I've talked to a lot of
7 operators. I'm in operations, too. I've talked
8 to HPs. And there's not one person that believes
9 that INEL's been honest and true, and it's been
10 that way -- and I've been out in operations 23
11 years, and I know for a fact that some of my dose
12 in the rare gas plant is higher than what it
13 shows -- sometimes for a whole yearly dose. So
14 that's just my opinion. That's my say. Thank
15 you.

16 DR. ZIEMER: Thank you very much. Anyone
17 else? Sir?

18 MR. JENSEN: I guess I don't need to state my
19 name again since you already know it, but one
20 thing I'd like you to know is that SMC and
21 everybody hides behind national security. I
22 think that's just a big fraud, due to the fact is
23 people's health is more important than a lot of
24 things. And when you're putting people's health
25 on the line, not telling them what they're being

1 involved in, working them without the proper
2 protection, without knowing what they're working
3 around, it's like sending you blindfolded into
4 something. And then -- and then they have the
5 gall to say it's national security; we can't tell
6 you. That's denying me the -- the ability to get
7 proper medical health care to try and help me. I
8 don't -- if I -- if I had something -- I knew
9 something that would you -- help you and I denied
10 you of it, how would you feel? And I know other
11 people feel the same way because they've been
12 denied the truth about what they've been around,
13 what the radiation count was. It's not been a
14 pretty story for a lot of people. Thank you very
15 much.

16 DR. ZIEMER: All right. Thank you again for
17 those added comments. Yes, sir?

18 MR. QUINN: I'm John Quinn. I'm a retired
19 worker at the site. I worked at the chemical
20 processing plant for 27 years. The lady that
21 spoke back there, I was there before -- I guess I
22 was one of the original ones, I guess, that kind
23 of started at the chem plant. I went there
24 shortly after the SL-1 incident when they formed
25 the decontamination facility to take care of

1 those who lost their lives in that reactor
2 incident. I worked in that facility for seven
3 years, with equipment that they originally put
4 there. And they had lots of problems. And I got
5 my dose reconstruction Saturday from NIOSH. I'm
6 not totally convinced of their findings and the
7 results and the dose that they had given me
8 because, just like a lot of them, we went into
9 these areas back in those days, in the early
10 sixties, it was half-face respirators with just
11 plain paper filters. And there was a time when
12 they all -- money was an issue. To keep those
13 operations going out there, when I first went to
14 work there, we decontaminated in that facility
15 the half-face respirators that the workers that
16 went in the hot cells to do the jobs, and we was
17 instructed to monitor those. If they read less
18 than 60 min-- counts a minute, we would reuse
19 them. We did that for two or three years, as I
20 remember.

21 Then they come out with a charcoal filter,
22 lot more money, and they said we got to use
23 these, you know, in hot areas. Well, sometimes
24 those hot areas, they was so hot that, you know,
25 we just had to throw them away.

1 And I come up through the years in this to
2 where we kind of got up to full-face respirators.

3 Finally got into air lines, finally got into
4 bubble suit. I've been through the whole works.

5 But the first seven years in my work out there,
6 I didn't see that.

7 We had ventilation problems. We had
8 monitoring problems, and I -- just like the lady
9 back there said, we went in to do the job. And
10 I'm just wondering if the people who are
11 estimating these NIOSH reconstruction, if they
12 really know and saw the places that we had to
13 work in, maybe they would -- we might get a
14 different evaluation. That's all I got to say.

15 DR. ZIEMER: Okay. Thank you, sir. Again
16 open the floor for anyone else that wishes to
17 speak.

18 (Pause)

19 DR. ZIEMER: If not, we are going to adjourn.
20 I feel like an auctioneer -- going once. Let me
21 --

22 MR. GRIFFON: Paul --

23 DR. ZIEMER: Oh, there is? Okay.

24 MR. GRIFFON: No, no, we --

25 DR. ZIEMER: Comment or question?

1 MR. GRIFFON: I just wanted to say as a
2 reminder, we're having another opportunity --

3 DR. ZIEMER: Oh, yes --

4 MR. GRIFFON: -- tomorrow afternoon. Is that
5 --

6 DR. ZIEMER: -- thank you.

7 MR. GRIFFON: Yeah.

8 DR. ZIEMER: The Board meets tomorrow again
9 all day. As you may know, our sessions are open.

10 You're welcome to attend. Although we did not
11 put it on the printed schedule, there is a public
12 comment period tomorrow afternoon right after the
13 lunch hour. I believe it's at 1:30. So if you
14 or any of your colleagues do wish to make public
15 comment tomorrow, you're welcome to do that. The
16 Board will be here at that time and will welcome
17 hearing from any of you that -- or others that
18 may not have been able to attend tonight, if you
19 know someone that wishes to comment, you might
20 let them know that, as well.

21 Let me thank you again all for coming. We
22 appreciate the input and will wish you goodnight
23 and hope to see many of you again tomorrow.

24 (Whereupon, the proceedings were adjourned at
25 approximately 7:45 p.m., to reconvene the next

day at 8:00 a.m.)

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