

Presidential Advisory Committee
Department of Health and Human Services
Centers for Disease Control and Prevention (CDC)
National Institute for Occupational Safety and Health
(NIOSH)
Advisory Board on Radiation and Worker Health

VOLUME I

The verbatim transcript of the Meeting of the
Advisory Board on Radiation and Worker Health held at
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In the following transcript (inaudible) signifies mechanical failure or speaker failure.

1 contributions.

2 I want to remind everyone -- Board members,
3 visitors, members of the public and staff members
4 from the various agencies -- to register your
5 attendance with us today. The registration book is
6 -- it is out in the corridor still? I guess it is.
7 But if you have not registered, please do so.

8 And then also for members of the public who
9 wish to make a statement or to comment to the Board
10 at the appropriate time in the agenda, please sign
11 up on the sign-up sheet that is also out there.
12 It's in the back of the room and Cori is in the back
13 and can direct you to that if you've not already
14 found it.

15 There are a number of handouts on the back
16 table you can avail yourself of. These are various
17 documents that have been generated over the past
18 several months, including the minutes of the
19 previous meetings of this body, the recommendations
20 of this body to the Secretary of Health and Human
21 Services, and other related documents that may be of
22 interest to you. I also would point out that all of
23 these documents, and others, as well, are on the web
24 site. You would go to the NIOSH web site and then
25 find the section on the worker's compensation

1 program and you'll find all of these documents and
2 others there, as well.

3 I hope all of you have, if you haven't
4 already got it, will please get an agenda so you
5 know what's before us for the next two days. I know
6 the Board members have the current version of the
7 agenda in their packet. There's been several
8 revisions of this over the past several weeks. The
9 one on the web site last week has been revised
10 slightly, but there are copies -- hard copies in the
11 back of the agenda, as well.

12 We will follow that agenda, at least
13 topically. We may adjust the time somewhat,
14 depending on what questions and discussion the Board
15 may have, and we'll take those modifications as
16 necessary as we proceed.

17 I would point out to the Board members that
18 the mikes that are distributed around your tables
19 have no on/off buttons on them, so they're on all
20 the time. That means be careful of sidebar
21 conversations, but also when you do wish to speak,
22 pull one of the mikes toward you and avail yourself
23 of that. That will help our recorders here to
24 transcribe properly what you say.

25 Others who have comments later may use the

1 back mike, or in some cases for members of the
2 public we may ask you to use the podium here so that
3 we can readily see you as you speak.

4 There will be some other housekeeping items
5 that come before us later in the meeting, but we
6 will proceed now with the agenda as it's presented,
7 and I'm going to call on Larry Elliott now to
8 officially welcome us. I would add my word of
9 welcome first -- I guess welcome myself as well as
10 others 'cause this isn't my place, but it's a
11 beautiful place to meet and we certainly are
12 enjoying the ambience of this location.

13 Larry Elliott serves both as Executive
14 Secretary of this Board and also as Director of the
15 Compensation Analysis Support Program for NIOSH. So
16 Larry, if you want to speak from there or you're
17 welcome to come up here.

18 **MR. ELLIOTT:** I'll just speak from here. I
19 have just a brief comment. I do welcome you all to
20 the -- I guess this is our eighth meeting. We had
21 seven meetings last fiscal year. We are preparing a
22 report for the Federal Advisory Committee Act,
23 Committee Management Office in the Department on the
24 activities of this Board, and that report will be --
25 a copy of that report will be available and shared

1 with you, as well, but it's a standard process that
2 we go through in end-of-the-year effort to document
3 the accomplishments of this Board, the purpose of
4 the Board and how the Board does its work. So I
5 just wanted to give you an insight and an
6 understanding that that will be forthcoming for the
7 last fiscal year.

8 Additionally, I'm reminded by Committee
9 Management Office that at each meeting we need to
10 start the meeting with refreshing our memories as
11 Board members about the waivers that you have all
12 been provided. We have matters of general
13 discussion on this agenda, but as we proceed in our
14 next series of meetings I anticipate that we're
15 going to be moving toward matters that are more
16 specific in nature and you'll all have to take that
17 into account, so this is just a gentle reminder that
18 each Board member refresh your understanding of the
19 waivers that have been granted to you as a Board
20 member and what you need to do to recuse yourself
21 from certain discussions.

22 The agenda has been modified slightly over
23 the last few weeks, and I apologize for that. I
24 also apologize to you for the late distribution of
25 your minutes. This is the nature of this program.

1 We're still playing catch-up in a lot of ways and
2 I'm very sorry that we didn't get the minutes to you
3 earlier for your review in advance of this morning.
4 We lost a whole box of information and minutes
5 happened to be in it, as I understand, and lost in
6 Albuquerque, but we did get them here this morning
7 for you.

8 Are there any questions of me at this point?

9 (No responses)

10 **MR. ELLIOTT:** That's it then. Thanks.

11 **REVIEW AND APPROVAL OF DRAFT MINUTES**

12 **DR. ZIEMER:** Thank you, Larry. The next
13 item on the agenda in fact is the review and
14 approval of the draft minutes. There are actually
15 two sets of minutes, one the minutes of the official
16 meeting that we held, the seventh meeting, and the
17 other the minutes for the telephone conference
18 meeting that was held. The seventh meeting was the
19 August 22nd meeting and the telephone conference
20 meeting -- wait, I may have that backwards. Right,
21 the telephone conference meeting was -- referred to
22 as the seventh meeting, was August 22nd. The
23 regular meeting was August 14th and 15th.

24 Now I'm a little concerned about the fact
25 that most of you haven't had a chance to go through

1 those minutes in detail, so I may ask that we defer
2 action till tomorrow, if that's agreeable. Would
3 everyone feel more comfortable with deferring action
4 till tomorrow? I would point out to you that I got
5 the minutes about a week ago. I'm always given the
6 opportunity to go through them first and catch all
7 the dangling participles and things like that. But
8 that also hit me at a time when I was actually on
9 travel, so I was actually going through the minutes
10 -- I sat in a restaurant in Omaha last week doing
11 the minutes of the teleconference, so that tells you
12 how -- and who knows what the results of that might
13 have been. So in any event, I have already gone
14 through them and done some mark-ups, but I think in
15 fairness everyone should have a chance to do that.
16 And then if it's agreeable without exception, we'll
17 actually take action first thing tomorrow morning.

18 Any objections?

19 (No responses)

20 **DR. ZIEMER:** Okay. Without objection we
21 will do that. We're basically looking for
22 substantive changes. If you have grammatical
23 changes -- you know, if you have your own dangling
24 participles you want to talk about -- we'll pass
25 those on separately, but we'll ask for substantive

1 changes in the content.

2 Any questions or comments on that?

3 (No responses)

4 **DR. ZIEMER:** Then without objection, we'll
5 postpone action on those minutes until tomorrow
6 morning.

7 **PROGRAM STATUS REPORT**

8 Which moves us up automatically on the
9 agenda to Dave Sundin. Dave is involved in the
10 legal aspects of -- well, I'm sorry, I'm getting
11 ahead of myself. We've got the wrong guy here.
12 Dave is the deputy director of the program, serving
13 under Larry Elliott, so Dave is going to give us his
14 regular program status report. Dave reported to us
15 last time, as well. So Dave, we welcome you back
16 for the program status report.

17 Dave, there's an on button there. Just push
18 that to the right and then -- and then clip that on
19 your --

20 **MR. SUNDIN:** How about now? Okay, that
21 sounds fine.

22 **DR. ZIEMER:** Can you hear me now?

23 **MR. SUNDIN:** Can you hear me now? Well,
24 good morning. This is really a fantastic place to
25 have a Board meeting, I've got to say that. So I'm

1 privileged to be here with you this morning and I
2 thought I'd give you a brief overview of the program
3 status. I'll follow the basic approach we've used
4 in previous Board presentations. And as you know,
5 September 30th marks the end of our fiscal year
6 2002, so for a lot of these indicators you'll get a
7 year's worth of statistics to show trends over the
8 -- really the first full year that we've been
9 receiving claims for dose reconstruction.

10 The Department of Labor is currently working
11 on approximately 13,700 non-SEC cancer cases. There
12 are more claims than that, but that's the number of
13 actual cases. There can be multiple claims on a
14 case. DOL has transferred over 8,000 of these cases
15 to NIOSH for dose reconstruction. We actually began
16 receiving cases from the Department of Labor on
17 October 11th of 2001. And as you can see, the
18 number of cases referred to us has increased each
19 quarter of the fiscal year. We're currently
20 receiving approximately 200 cases per week from --
21 combined from the four district offices of the
22 Department of Labor.

23 As we receive referrals from the Department
24 of Labor we immediately send each claimant a letter
25 to let them know that we've received their claim for

1 dose reconstruction. And in that letter we tell
2 them about the steps their claim will go through
3 while we have it and how they can contact us to
4 monitor their progress. We also log each case into
5 our computerized claims tracking system. We
6 electronically scan all the documents in each case
7 file and we also create and maintain a paper file
8 system.

9 You can see that the majority of the claims
10 involve employees who worked at DOE sites, but about
11 15 percent involve employment at atomic weapons
12 employer sites, or AWE's.

13 The DOL referral summary sheet which
14 accompanies each case when they refer it to us lists
15 the verified covered sites where the employee
16 worked, and this permits us to direct our requests
17 for radiation exposure information to the
18 appropriate DOE points of contact. We've sent
19 nearly 6,800 requests for personal radiation
20 exposure information to our 12 DOE points of
21 contact, and we've received responses to slightly
22 more than 50 percent of these requests.

23 We continue to work closely with the DOE
24 Office of Worker Advocacy and our designated points
25 of contact at the sites to ensure that we get the

1 kind of exposure information that we need to conduct
2 dose reconstructions in a timely manner. We're
3 continuing also to explore ways to expedite the
4 fulfillment of our information requests.

5 We send each DOE point of contact periodic
6 status reports on the requests we've sent and the
7 responses we've received. These reports include a
8 listing of all requests which are 60 days or more
9 outstanding without a response.

10 **DR. MELIUS:** Yeah, Dave, just could you
11 clarify what you mean by a DOE response? Is that an
12 acknowledgement or is that sending records or
13 information back?

14 **MR. SUNDIN:** That's actually sending some
15 exposure information back.

16 **DR. MELIUS:** Okay.

17 **MR. SUNDIN:** And I'll get into it a little
18 bit later where that leaves us in terms of having
19 enough information to do a dose reconstruction.
20 It's any response that contains exposure
21 information.

22 Our discussions with DOE on the terms of a
23 memorandum of understanding between HHS and DOE are
24 continuing. The purpose of this MOU is a limited
25 though important one. We want to achieve agreement

1 between HHS and DOE on how we will carry out those
2 responsibilities in EEOICPA and the Executive Order
3 which require collaboration. The discussions have
4 been useful, and I hope an agreement will be reached
5 soon.

6 This chart just depicts how our caseload has
7 gone over the past several months and shows where we
8 are with our efforts to gather the exposure
9 information needed to proceed with claimant
10 interviews and dose reconstructions. The number of
11 requests for DOE information -- the number of
12 requests for DOE information is less than the number
13 of claims received because for some sites -- that is
14 principally the AWE's -- we've not yet identified a
15 point of contact that's able to provide exposure
16 information. Also, even in the cases where we have
17 received a response from DOE there may be a need for
18 follow-up requests to DOE as the information
19 provided in the initial response is more fully
20 analyzed.

21 Once we've assembled and reviewed all the
22 relevant information from NIOSH records and received
23 and examined the information from DOE, we schedule
24 an interview with the claimant. As of today we've
25 conducted interviews with 164 employees and

1 survivors. We currently have 36 dose
2 reconstructions underway. This means we've
3 received, assembled, reviewed and evaluated the
4 readily available information pertinent to a claim,
5 completed the claimant interview and assigned the
6 case to the NIOSH health physicist. For 11 claims
7 we've completed the draft dose reconstruction report
8 called for in our rule, completed the closeout
9 interview with the claimant and received a completed
10 OCAS-1 form which closes the dose reconstruction
11 process. Nine of these cases have been transmitted
12 back to the Department of Labor, along with the
13 complete administrative record for final
14 adjudication. Of course that step includes a
15 determination of the probability of causation.

16 We intentionally make it very easy for
17 claimants to contact us, and they do so. The number
18 of phone calls received in OCAS has increased
19 substantially each quarter as we receive more and
20 more claims. We're currently receiving an average
21 of 60 phone calls per day, which keeps us connected
22 with claimant concerns and issues and motivates us
23 to continue our efforts on their behalf.

24 I hope most of you will agree that the OCAS
25 web site is an unusually rich source of information

1 on this program. It also provides a channel through
2 which claimants can contact us. We received over
3 600 claim-related e-mails, and our goal is to
4 respond to each one of them within 24 hours.

5 You'll be hearing more about some recent
6 noteworthy developments and accomplishments later
7 today. We achieved one of our major goals, the
8 award of a five-year contract for much-needed
9 support to Oak Ridge Associated Universities on
10 September 11th. Dr. Jim Neton will provide more
11 details in his presentation, which immediately
12 follows this one.

13 As required by an amendment to EEOICPA which
14 was enacted on December 28th, 2002, NIOSH recently
15 completed a progress report on a study of residual
16 contamination of certain covered facilities under
17 the Act. Mr. Grady Calhoun will describe the study
18 findings to date and our plans for completing the
19 final report, as required by the amendment.

20 And finally, as you're aware, HHS published
21 a notice of proposed rule-making on procedures for
22 designating classes of employees as members of the
23 Special Exposure Cohort under EEOICPA on June 25th.
24 The public comment period closed on August 26th, and
25 we received a wide variety of comments from 23

1 individuals, labor and advocacy groups and
2 scientific organizations. All of these comments can
3 be viewed on our web site. Many comments focused on
4 feasibility of dose reconstructions, timeliness, and
5 the use of NIOSH-IREP for determining health
6 endangerment.

7 We're currently drafting solutions that we
8 believe will substantially improve the proposed
9 rule. If we receive support for these changes
10 during the review process, a determination will need
11 to be made concerning whether the revised rule can
12 be published as a final rule or must be issued for
13 public comment as a proposal. We believe that we
14 are on track for publishing a revised rule or, if
15 necessary, a second proposed rule in January.

16 Thanks for your attention. I'll try and
17 answer any questions you might have at this point.

18 **DR. ZIEMER:** Thank you. Henry?

19 **DR. ANDERSON:** Yeah, you've got a number of
20 phone calls. Are those individual calls or
21 individuals who called?

22 **MR. SUNDIN:** Those are individual calls.
23 Some callers called multiple times.

24 **DR. ANDERSON:** Yeah, I was -- I mean it
25 could be 60 people 60 times each.

1 **MR. SUNDIN:** We actually did a simple
2 analysis of that early on in the program and many
3 people haven't called at all. Most people call
4 once, but there's a handful of people that call many
5 times.

6 **DR. ZIEMER:** Jim?

7 **DR. MELIUS:** Yeah, a couple of related
8 questions. What's the status of the MOU with the
9 DOE?

10 **MR. SUNDIN:** We're still discussing that.
11 It's -- right now it is with DOE. We're expecting
12 comments on our last draft to them.

13 **DR. MELIUS:** And that's what's holding up
14 the issue about some of the older atomic weapons
15 sites in terms of getting contact and getting
16 exposure information? It's a considerable number of
17 cases -- I mean it seems to be --

18 **MR. SUNDIN:** Certainly the issue of DOE
19 providing assistance to the degree that they can and
20 identifying contacts for some of these sites is an
21 element of the MOU. I will say that we're not
22 delaying going forward with activities in many areas
23 pending the resolution of the MOU, and we have
24 received some corporate contact information from DOE
25 on a number of these sites. Whether or not those

1 corporate contacts are in a position to provide
2 exposure information is the other question. And we
3 have identified some contacts as some of the larger
4 AWE sites, but there's a number of them of course we
5 have not.

6 **DR. MELIUS:** Okay. So do you have -- I mean
7 is there a planned approach for dealing with those
8 workers then?

9 **MR. SUNDIN:** Well, one approach would be to
10 begin with the corporate contacts, obviously, and
11 burrow down and see whether or not -- and that's
12 likely to be a task that our contractor will take up
13 more vigorously than we've been able to at this
14 point.

15 **DR. MELIUS:** Okay. And then as another
16 related follow-up question, and this may be more --
17 better answered during Jim Neton's presentation, so
18 tell me if you can't answer, but have you done any
19 sort of projections on where this will take you in
20 terms of dealing with the numbers and so forth? It
21 seems to me that DOE is falling further behind
22 getting information to you. I mean the backlog's
23 getting -- at least numerically -- greater. And
24 then obviously in terms of completing dose
25 reconstruction -- is there some sort of a way of

1 projecting out the workload and when some of these
2 claims will get handled in some way? Or should I
3 wait and ask that -- is it better answered in terms
4 of dealing with the contract and so forth?

5 **MR. SUNDIN:** I think probably Jim is going
6 to deal with the capacity issues of the contract,
7 unless you say -- unless you -- at least can tell
8 you what the scope of work calls for in terms of
9 capacity and where that might leave us a year from
10 now in terms of backlog.

11 **DR. MELIUS:** Okay.

12 **DR. ZIEMER:** We'll have Tony and then Roy.
13 Before Tony starts, I just -- looking at your claims
14 processing chart, it looks like the volume coming
15 back from DOE has increased substantially, but
16 they're still falling behind further because the
17 other volume's going up.

18 **DR. MELIUS:** Exactly. Yeah, that's my...

19 **DR. ZIEMER:** So the further they get -- the
20 more they get the behinder they get or something.

21 Okay, Tony?

22 **DR. ANDRADE:** Dave, please refresh my memory
23 with respect to the number of claims in process at
24 the Department of Labor versus those that have been
25 forwarded on to NIOSH for dose reconstruction.

1 Currently -- or at least at the end of the fiscal
2 year -- there were some 5,000 cases still within the
3 Department of Labor. Do you expect all or most of
4 these to be forwarded on for dose reconstruction?

5 **MR. SUNDIN:** That's hard for me to say. The
6 Department of Labor of course basically has to
7 qualify or determine verified employment and disease
8 condition, so I'd have no idea how many of those
9 5,000 that we haven't seen may fail on either of
10 those two issues. I suppose the best way to say it
11 is the maximum number that might come over out of
12 those 5,000 would be 5,000. But of course their
13 caseload continues to increase with new
14 applications, so that's just a snapshot of what the
15 total number of -- or the total number of cases over
16 there is right now.

17 **DR. ZIEMER:** Roy DeHart.

18 **DR. DEHART:** Regarding the Special Exposure
19 Cohort public comment period, and reading that --
20 those comments -- there were several that were
21 frankly contradictory in terms of recommendations.
22 Will NIOSH be responding to those independently?
23 And if so, will the Board have access to that
24 information or are we waiting till January until a
25 decision's been made as to how you will handle --

1 **MR. SUNDIN:** Typically the way this goes is
2 that the comments are responded to in the preamble
3 of the new proposed rule, and not always do you get
4 individual responses to individual comments. They
5 are grouped by subject area, more or less, and if
6 the agency has a response which covers several
7 comments, then that's the way it will be presented.
8 So my sense is it would be -- the agency response to
9 public comments would be found in the preamble of
10 the next version of the rule.

11 **DR. ZIEMER:** Gen and then Jim.

12 **DR. ROESSLER:** You stated that nine dose
13 reconstructions have been completed by NIOSH and
14 that some others are underway. When will the
15 transition take place for the support contractor to
16 begin picking up? And if this is going to be
17 covered by Jim later, I'll just wait until then.

18 **MR. SUNDIN:** I think that probably would be
19 better addressed by Jim. The transition is
20 underway, let's put it that way, but in terms of
21 more specific information as to how that will affect
22 the rate of completed dose reconstructions coming
23 out, I think maybe Jim would be in a better
24 position.

25 **DR. ZIEMER:** Jim?

1 associated subcontractors with the team. The two
2 main ones as far as dose reconstruction activities
3 are concerned are Dade Moeller & Associates out of
4 Richland, Washington and MJW Corporation based out
5 of a suburb of Buffalo, New York. Dade Moeller &
6 Associates -- it's a little more complicated than
7 this, but essentially Dade Moeller & Associates is
8 going to be involved primarily with dose
9 reconstruction research issues and external
10 dosimetry, and MJW has a lot to do with the internal
11 dose reconstruction, although there are some other
12 areas of overlap that I'll talk about a little
13 later.

14 It is a five-year, incrementally-funded
15 contract, so it's a five-year contract, but the way
16 the government operates, money gets distributed or
17 allocated on an annual basis into the contract pot.
18 And this addresses a little bit of the question
19 maybe that Dr. Melius was asking, is how are we
20 going to accomplish -- what are we going to
21 accomplish with this contractor? And the original
22 RFC, the request for contract, called for the
23 reconstruction of at least 8,000 doses per year.
24 It's not constrained to that. That was a target
25 that was put into the contract so that we could have

1 an equal footing to evaluate all the potential
2 bidders. But -- so the contractors were required to
3 propose 8,000 per year, and then provide provisions
4 for expansion and contraction, waxing and waning in
5 response to the demands -- the fluctuating demands
6 that are essentially unpredictable for a program of
7 this size and nature.

8 There are a number of personnel on there. I
9 believe the total, if we added them up, would exceed
10 100 individual personnel working on this contract,
11 so I've outlined a few of the key personnel on the
12 project. And a number of these I think some of you
13 will recognize. They've been involved in health
14 physics activities for quite some time.

15 With us today in the audience are Dick
16 Toohey, who's the project director at Oak Ridge
17 Associated Universities. Dick has had a number of
18 years of health physics experience, in dosimetry
19 particularly. And a little further down, Jim
20 Griffin is heading up the dose reconstruction
21 consolidation effort and he's -- he works with MJW
22 Corporation.

23 Other notable personnel on the project are
24 Phil Wallace from ORAU who will be heading up the
25 database management efforts. Phil will be working

1 with not only ORAU personnel but staff from MJW
2 Corporation.

3 Bill Tankersley, who's got a long past
4 history involved in dose reconstruction research
5 activities from ORAU will be heading up that
6 activity.

7 Priscilla Campbell from ORAU will be
8 responsible for administration of the contract and
9 will serve as Dick Toohey's deputy director.

10 And heading up the individual internal dose
11 and external dose are Liz Brackett and Steve Merwin,
12 respectively. Liz is with MJW Corporation and Steve
13 Merwin is with Dade Moeller. Liz and Steve actually
14 report to Jim Griffin, who will consolidate all the
15 dose reconstruction activities as far as
16 coordinating the scheduling, planning day to day
17 activities, that sort of thing, and Jim reports to
18 Dick -- his organization.

19 The contract had six areas of support, so
20 it's a fairly broad-ranging contract. We didn't
21 want to limit ourselves just to do a dose
22 reconstruction, but we felt that we needed support
23 in a number of areas, and these are outlined here.
24 Starting a little further down, dose estimation and
25 reporting, bullet item four (sic), is the most

1 obvious task that we've asked our contractor to do.
2 But also they're going to be responsible for
3 performing all the claimant interviews that we are
4 committed to in the rule.

5 But between interviewing and reporting, they
6 need to do a lot of dose reconstruction data
7 collection and research, so those are task two --
8 bullets two and three up there. They'll be tasked
9 with going out to the sites and essentially
10 establishing these site profiles that we've talked
11 about and I'm going to address tomorrow afternoon, I
12 think -- or morning. As far as establishing site
13 profiles, determining -- looking, evaluating, air
14 sampling, records, surveys, those sort of issues
15 will be under the responsibility of the contractor.

16 Once they collect all this information,
17 there will be dose reconstruction research
18 activities conducted, and that is to try to relate
19 certain work areas and work activities and job
20 descriptions with certain exposure profiles and that
21 sort of thing. So that all falls under the guise of
22 dose reconstruction research and that will be housed
23 in bullet item one, which is this database
24 management task that they've been asked to perform.

25 NIOSH ourselves will actually own, operate

1 and control the database, but ORAU themselves will
2 have their own parallel and develop databases that
3 they're involved with claims tracking, profile
4 development, that sort of thing. So we'll be
5 running parallel systems here.

6 And last is sort of a catchall one,
7 technical and program management support issues as
8 they arise. We couldn't possibly envision all
9 activities that we may need to perform under this
10 contract.

11 I'd like to just take a little time to talk
12 about something that's been of key interest to NIOSH
13 and our stakeholders in letting this contract, and
14 that's conflict of interest. We asked all bidders
15 on the contract to propose -- provide a conflict of
16 interest plan to delineate how they would propose to
17 perform this, given that it's likely that many
18 people working for the contractor will have had ties
19 or employment histories with the Department of
20 Energy themselves or Department of Energy
21 contractors. So I've abstracted -- I think there's
22 nine areas in the ORAU plan -- and this is actually
23 on our web site, so I would encourage everyone who
24 has not looked at this to go out to the NIOSH OCAS
25 web site and read it. It's fairly short, but it's

1 actually I think pretty good. It's about six pages
2 long.

3 I've taken out the main bullets, and the
4 first several deal with the fact that no contractor,
5 subcontractor or employee can actually do a dose
6 reconstruction or review one if they've actually
7 performed work at that site regarding the policies
8 and procedures at that site related to dosimetry, or
9 if they've actually done dose assessment at those
10 sites. Those are fairly obvious conflicts of
11 interest.

12 The next bullet item actually deals more
13 with the organizational level of conflict of
14 interest, which is no contractor element will review
15 or participate in a dose reconstruction if the
16 contractor itself was a prime contractor associated
17 with any of the teaming partners or associate
18 subcontractors at that site. So even if one of the
19 dose reconstructionists had not been involved at a
20 given time, if they now work for a contractor who
21 has done something there, they would be prohibited
22 from doing the dose reconstruction or reviewing it.

23 And the next bullet item talks -- addresses
24 the issue of conflict of interest when someone had
25 been -- performed expert witness, either testimony

1 or a non-testifying expert analysis on behalf of DOE
2 or DOE contractor.

3 The next one addresses conflict of interest
4 related to if someone actually were performing dose
5 reconstructions for a co-worker. That would
6 certainly not be a good situation to be in, so he'd
7 be prohibited from doing that if any one that you're
8 reviewing had been a co-worker at that site.

9 And the next issue deals with another
10 organizational element, which contractor --
11 subcontractors or contractors cannot -- will be
12 prohibited from bidding on work related -- at other
13 DOE sites related to the dosimetry programs,
14 according to the terms of this contract.

15 And also key personnel of the ORAU team will
16 not have a conflict of interest with managing the
17 project. That's somewhat obvious. Or carrying out
18 or marketing related to activities in this area of
19 expertise.

20 The final two deal more with the
21 transparency issue, as we call it, or the -- which
22 is that each supervisor in dosimetry will be
23 required to complete and sign a form that
24 essentially outlines their employment history and
25 where there may be conflict of interest, and ORAU

1 will maintain these forms as auditable records and
2 they will be scanned -- we're still working out with
3 ORAU whether it makes sense to post these on a web
4 page or have some abstracted database that contains
5 essentially the elements of what's on these forms.
6 There's possibly some privacy issues associated with
7 this, but nonetheless, it will be transparent. It
8 will be out there to the public in some form as to
9 what potential conflicts of interest would be for
10 all supervisors, dosimetrists and reviewers working
11 on the program.

12 And the last one talks about identifying the
13 dosimetrist to the claimant as to who either
14 performed the dose reconstruction or reviewed it,
15 and that will be attached to each dose
16 reconstruction. And they have proposed, at least at
17 this point, along with a short biographical sketch
18 to be attached to dose reconstruction, so that's an
19 option at this point. They have not talked about
20 how that would work at this point, but that's in
21 their conflict of interest plan.

22 Okay. Well, where are we at so far to date?
23 We've made some very good progress. We had a
24 kickoff meeting shortly after the contract was let,
25 within a week and a half, I believe it was, where we

1 met with all the key -- the principals and -- of the
2 ORAU team at NIOSH and their information transfer.
3 ORAU has had -- there's three short-term
4 deliverables that were listed in the request for
5 contract. It says that -- on this bullet that
6 they're on track to meet the early deliverables --
7 this was written prior to October 11th, which was
8 the due date for those deliverables, and they have
9 met all three of those deliverables thus far.

10 The 800 number is actually up and running
11 and they've hired a person who will answer it. I
12 will say that it's not out there actively taking
13 claimant calls yet, though. There are some start-up
14 issues associated with that, but they've met the
15 deliverable.

16 They've also been engaged in a design of a
17 claimant tracking database and dose reconstruction
18 research database. That's the data dictionary, the
19 data elements, the interface with the NIOSH
20 database. All that has been accomplished and
21 delivered to NIOSH as of last Friday, so it's in our
22 possession. We're reviewing it now to see how well
23 it will interface with our work activities.

24 They've also developed a data security plan
25 related to how they're going to handle privacy of

1 claimant information over a distributed web-based
2 system. ORAU has proposed to work this system on a
3 nationwide basis with their dose reconstructionists
4 located about the country, and so there's some
5 issues related to security of that information, as
6 well as establishing a secure link between the NIOSH
7 facility in Cincinnati and the ORAU facility that's
8 based in Cincinnati, as well. A T-1 line it's
9 called.

10 Recruitment process is well underway for
11 CATI's -- computer-assisted telephone interviews.
12 They've interviewed numbers of people. They've
13 actually -- there are people on-site now working in
14 our CATI office, ORAU representatives. As of last
15 week -- I didn't verify this, but there were some --
16 or yesterday, I believe, ORAU was to start doing
17 some dose -- computer-assisted telephone interviews
18 out of the office -- the area that we've established
19 in Cincinnati.

20 We've had several meetings with
21 representatives of both the internal and external
22 dosimetry staff related to procedures under
23 development. ORAU will develop procedures, but we
24 will be in the loop and review all procedures that
25 they develop that fall underneath our two

1 implementation guides that are out there.

2 And we've also completed the initial dose
3 reconstruction training that was in our contract.
4 Within 30 days we're to train up to six people from
5 ORAU in the operation of our internal dosimetry
6 software and go over the approach for internal dose
7 reconstructions. That was done last week sometime.
8 I think Tuesday or Wednesday, I've forgotten
9 exactly, but we've accomplished that.

10 We've asked ORAU to -- as a priority issue,
11 one is to start getting the CATI interviews done
12 because we have a huge backlog of those, as you
13 could tell from Dave Sundin's presentation. We've
14 also asked them to go and review the DOE and DOL
15 submissions that are in our hands. I believe Dave
16 said that we had somewhere slightly less than 5,000
17 responses from the Department of Energy. The fact
18 is that NIOSH has not actually physically gone and
19 reviewed every one of those for completeness of the
20 data. We've pulled out and done samples from
21 different sites to make sure that what they're
22 sending fits our needs, but we just have not had the
23 staff at hand to go and review every single one. So
24 we've already had staff from ORAU in Cincinnati
25 going through the records and reviewing. And we've

1 asked them to start with claimant one and go through
2 and review the DOE information for suitability to
3 conduct a dose reconstruction. And those that they
4 identify that are not suitable -- that do not have
5 sufficient information to do a dose reconstruction,
6 to assemble that and then we're going to start
7 issuing requests to the Department of Energy for
8 follow-up information on those dose reconstructions.

9 On the other hand, the ones that they do
10 identify that are -- have information that are
11 suitable to move forward, they will be flagged. I
12 don't -- they've flagged a number of these already.
13 They're moving out into the ORAU files and they will
14 start performing dose reconstructions on those that
15 are ready to go.

16 As far as time frame goes on those, we've
17 had early discussions. We're hoping by the end of
18 the month or early November that ORAU will start
19 producing some dose reconstructions through the
20 pipeline. Of course, with something this large and
21 a transfer of this magnitude, it's going to take a
22 while to get up to speed. We're not going to be
23 performing 167 dose reconstructions a month on
24 average that we hope to get to right away, but I
25 would say within a couple of months there'll be a

1 significant improvement and the dose reconstructions
2 will be getting there.

3 ORAU has done -- has taken claims managers
4 who will actually be -- have a health physics
5 background and they're going to be assigned to DOE
6 regions that parallel the NIOSH structure. NIOSH
7 has a claims specialist, or what we call a public
8 health advisor, that interfaces directly with each
9 of the four Department of Labor district offices.
10 ORAU will have a health physics background person
11 that will be tied to the NIOSH person so that they
12 can manage a group of claims from each of those
13 district offices. It's a nice feature and in some
14 ways it makes a lot of sense. The district offices
15 themselves, although geographically-based, do sort
16 of fall around production operations activities.
17 You have the -- Seattle, you have the
18 Richland/Hanford area, that sort of thing.
19 Cleveland area handles a lot of AWE's. The
20 Jacksonville office has things like Savannah River,
21 Oak Ridge, so it makes some sense.

22 They have -- ORAU has rented a Cincinnati
23 office space. They've leased it. They're occupying
24 a temporary facility right now there while they
25 build out their permanent facility. That's going

1 very well. I think by the middle of November they
2 will occupy their permanent leased space. And I've
3 forgotten the exact number, but there will probably
4 be somewhere in the vicinity of 30 to 40 ORAU
5 representatives or teaming partners based out of
6 that Cincinnati office.

7 So things are moving forward. We're making
8 progress. I'd be happy to answer any questions you
9 might have.

10 **DR. ZIEMER:** Before we get into the specific
11 questions, just for the benefit of the Board, Jim
12 has identified the fact that Richard Toohey is here
13 from ORAU and Richard, if you'd wave your hand or
14 something, we'd like to have the Board identify you.

15 **DR. TOOHEY:** Right here.

16 **DR. ZIEMER:** We're glad to have Richard here
17 this morning.

18 **DR. NETON:** And Jim Griffin.

19 **DR. ZIEMER:** And Jim, okay, I didn't
20 realize. Good, thank you.

21 Let me start the questioning and then I
22 think Gen, you waved your hand? Okay. And Jim,
23 okay. We'll go down the line.

24 I'm concerned about security of the data,
25 and I'd like to ask if NIOSH has had any outside

1 computer security experts look at the ORAU security
2 plan. Who's determined that that plan is adequate
3 is what my question is.

4 **DR. NETON:** We're working that in
5 conjunction with the CDC computer people that
6 represent, you know, CDC, their computer --

7 **DR. ZIEMER:** There are computer people and
8 there are security experts, and I'm asking
9 whether --

10 **DR. NETON:** Larry may be able to speak a
11 little more directly.

12 **DR. ZIEMER:** Do we have people who really
13 are computer security experts, 'cause there's a lot
14 of computer people who are not security people.

15 **MR. ELLIOTT:** Yes. Within the Centers for
16 Disease Control, which NIOSH is one -- an institute,
17 but it's one of the centers -- we're all required to
18 submit security plans on database management systems
19 that are reviewed, approved, modified, evaluated,
20 investigated even by individuals in what is called
21 IRMO -- I-R-M-O -- which is our Information Resource
22 and Management Office in CDC. And these people are
23 very well qualified to identify breaches in security
24 that might result from an improperly-established
25 database management system. They're very cognizant

1 of new techniques to breach fire walls, techniques
2 that are used to create wormholes in fire walls and
3 this is taken very, very seriously because of the
4 very sensitive, personal, private information that
5 CDC has. Not only on this program, but a number of
6 other programs that you might be aware of -- HIV and
7 AIDS and -- you know, a number of these kind of
8 programs, so they do take this very -- exceedingly
9 seriously. And I think that their rigorous review
10 will put us in good stead here.

11 **DR. ZIEMER:** Thank you. Gen?

12 **DR. ROESSLER:** You mentioned providing short
13 bios for some of the personnel, and I think it would
14 be helpful, as soon as possible, to get short bios
15 for especially the key personnel you had listed on
16 the slide. That's one comment.

17 The second one I think you've already taken
18 care of, and that was to introduce the personnel
19 that you mentioned were here. But along with that,
20 Paul, don't you usually ask the audience to
21 introduce themselves at some point in the meeting?

22 **DR. ZIEMER:** Yes, I normally do that, and
23 I've found from past experience that to do that
24 first thing in the morning we miss a lot of people,
25 so I'm waiting till later in the morning when all

1 the stragglers arrive. We will do that, though, in
2 a little bit.

3 Who was next?

4 **DR. MELIUS:** I think I was.

5 **DR. ZIEMER:** Jim?

6 **DR. MELIUS:** This might be -- I have some
7 questions on the conflict of interest policies, and
8 maybe you could click back through the slides. I
9 have a question on the second conflict of interest
10 slide.

11 **DR. NETON:** I'll get there.

12 **DR. MELIUS:** The first bullet there, that
13 applies only to where they are currently the prime
14 contractor, team member, et cetera, there. It does
15 not apply to their past work? Participate or review
16 for those DOE states (sic) where it is the prime
17 contractor --

18 **DR. NETON:** Right.

19 **DR. MELIUS:** -- or intends to -- well, first
20 go back to "is" --

21 **DR. NETON:** Right.

22 **DR. MELIUS:** -- does not apply to their
23 past?

24 **DR. NETON:** That statement does not address
25 that. Maybe Dick could elucidate that a little bit.

1 **DR. TOOHEY:** Well, certainly as the
2 statement exists, it says is currently. And the
3 only one we're aware of is of course ORAU operates
4 the Oak Ridge Institute for Science and Education
5 for DOE, so any claims -- and I think there's seven
6 or so -- from that in the pile, at least as of a
7 year ago, would have to be conducted directly by
8 NIOSH personnel. We won't even touch those.

9 I'm not aware that any of our partners have
10 -- Dade Moeller or MJW -- acted as primes or team
11 members to a prime managing dosimetry programs. And
12 we can certainly research that and if we -- if NIOSH
13 and the Board thinks it's advisable to make that
14 retroactive, we certainly would have no problem
15 doing that.

16 **DR. MELIUS:** And then related to that is how
17 do you determine -- intend to determine intent?
18 Intends to be within 12 months. I mean I intend to
19 do a lot of things within 12 months -- lose 30
20 pounds, et cetera. How do you judge on --

21 **DR. TOOHEY:** I think an operational
22 definition of intent is submitting a proposal to do
23 so.

24 **DR. MELIUS:** Okay, that's -- I needed to
25 know.

1 And then I don't know if we need the slides
2 for this, but I'm a little concerned that some of
3 what I've referred to as the transparency issues
4 seem to be up in the air, whether -- what
5 information or whether information would be put on
6 the web site and whether -- at least biographical
7 sketch information.

8 **DR. NETON:** The substance of what's on there
9 will be on the web site. Whether or not we post
10 forms that have a detailed employment history with a
11 person's signature on there on the web, we need to
12 -- there's some Privacy Act issues for protection of
13 the dose reconstructionists themselves (sic) that I
14 think we need to address. I mean -- you know, they
15 have proposed to put the form out there. We need to
16 work out whether it makes sense to put the form or
17 some abstracted information from that form that
18 could be retrieved by someone who so desired. But
19 signatures out there on the web and stuff I'm not
20 sure makes sense.

21 **DR. MELIUS:** Well, I'm not sure of
22 signatures, either, but I think the type of
23 information to have out there is going to be
24 critical to the -- how people view the program and
25 the credibility of the program. So it worries me

1 when I see you referring to a short biographical
2 sketch, which -- you know, was born in such and
3 such --

4 **DR. NETON:** No, no, no, I wish I had an
5 example of the form, but it would detail every
6 employment -- the employment history of the person
7 doing the dose reconstruction so that one could come
8 to their own conclusion whether or not they worked
9 at a site or had an affiliation with a site that met
10 one of the criteria that are outlined in these
11 conflict of interest statements.

12 **DR. MELIUS:** And then how does that differ
13 from the biographical sketch or abstract you're
14 sending to the claimant? 'Cause a lot of claimants
15 will not have access to the internet and I think --
16 how do you intend -- why not just give them that --
17 that same information to the claimant?

18 **DR. NETON:** It's quite possible we could do
19 that. Like I say, we've not quite fleshed out the
20 exact details of how we're going to address this
21 issue. I mean these are proposed in here, and I
22 think in substance we'll enact all of them, but the
23 exact forms they're going to take -- whether it's a
24 biographical sketch or just a bulletized work
25 history, or we could even have it so the claimant

1 could request more detailed information if they so
2 desired, if the biographical sketch weren't
3 sufficient -- is still yet to be worked out.

4 **DR. MELIUS:** Well, I mean you're intending
5 to have this contract to go to work and start
6 submitting information within the next month or so.

7 **DR. NETON:** That's correct.

8 **DR. MELIUS:** So I think -- I certainly -- I
9 think that kind of information -- as a Board member,
10 I'd like to be able to review and look at. I think
11 the Board ought to comment on 'cause I think it's
12 going to be critical to the credibility of what this
13 contractor does and how their work is being --

14 **DR. NETON:** We certainly can do that.
15 There's a lot of issues that we're working out right
16 now. The contract --

17 **DR. MELIUS:** You know, I understand those
18 logistics and I'm not telling you to delay having
19 them do the work until you do that, but at least
20 let's --

21 **DR. NETON:** Sure.

22 **DR. TOOHEY:** I would just comment on that
23 that I've instructed all our team members to start
24 collecting that information from all their sub-sub-
25 contractor personnel and get those forms completed

1 and signed.

2 **DR. MELIUS:** Okay. Thank you. Finally I
3 have a question again related to conflict of
4 interest in terms of the supervision of both that,
5 as well as this overall contract. My understanding
6 is you have essentially yourself and three other
7 people working --

8 **DR. NETON:** That's correct.

9 **DR. MELIUS:** -- on oversight in this area
10 and I -- at least it's pretty clear to me that
11 you've got an impossible task to try to do well,
12 looking at 8,000 dose reconstructions coming in a
13 year, how do you do the kind of quality control,
14 conflict of interest oversight, all the other --
15 plus all the other program activities? And this
16 seems to be a -- I mean a growing -- growing problem
17 for you and for the -- for this program. And again,
18 there can be quality control within the contractor
19 and that was included in the contracts -- but I
20 think, again, you're -- NIOSH is going to be signing
21 off on these and ultimately responsible. You keep
22 telling us that. And I just don't see how you can
23 get it done and done effectively and --

24 **DR. NETON:** A good observation that's not
25 lost on me.

1 **DR. MELIUS:** I know.

2 **DR. NETON:** I've spent a lot of sleepless
3 nights. As Dave Sundin did indicate that we are at
4 our approved staffing level of -- well, I think
5 we're 21 out of 22 FTE's and there's one position
6 out there for a paralegal I think that has not been
7 filled. But I have been asked by Larry to put
8 together a staffing plan or staffing requirements
9 plan that he could review and evaluate and determine
10 what our needs will be, and he could move that
11 forward to try to augment our staff, if he sees fit.

12 **MR. ELLIOTT:** If I could add to that, yes, I
13 -- Dr. Howard and Dr. Rest, the director of NIOSH
14 and deputy director of NIOSH, are expecting a
15 proposed plan from me to add additional staff to
16 OCAS and include -- that plan will have to address
17 not only the issues you brought forward, Dr. Melius,
18 about review of all these dose reconstructions that
19 will be forthcoming, but also it's going to have to
20 address our claims receipt, claims processing,
21 communications with claimants. There's a variety of
22 efforts that I feel personally that we need some
23 Federal position assistance on that we can't
24 accommodate right now with the staff of 22.

25 Also let me just add this, for the Board's

1 understanding. It's my intention that in about six
2 to nine months we will commission a independent
3 review of conflict of interest, management and
4 control, not only concerning -- that review not only
5 concerning the contractor, but it will also address
6 how conflict of interest is managed and controlled
7 and addressed within this Board, and it will also
8 address the same within my staff. So we're going to
9 put together a commissioned review to evaluate that
10 across this whole program within NIOSH's
11 responsibilities. And I think that needs to be
12 done, and I would welcome any thoughts or comments
13 you might have on how to go about doing so, about
14 commissioning such an independent review.

15 **DR. MELIUS:** Yeah, I think -- at least I
16 personally would agree with a -- that that would be
17 helpful, but I think what's much more important at
18 this point is the perception of the program from the
19 point of view of the claimants as they're going
20 through the process. And as we all know, just one
21 mistake, one person -- you know, somebody not
22 revealing where they worked or something or -- you
23 know, something like that, one -- it may not even --
24 you know, it's a perceived conflict of interest, not
25 -- maybe not even be something very serious, can

1 seriously undermine the credibility of the program,
2 as any conflict of interest -- so I think obviously
3 the attention is needed now, as well as a review
4 nine months from now, to this issue.

5 I'd also ask the Board to consider later on
6 in this meeting going on record in some way of
7 supporting -- I think what is, to me, becoming an
8 urgent need for better staffing for this program. I
9 think it's within our purview to do this. I know
10 we've commented on it at previous meetings -- first
11 meeting that we had -- but I really think that we
12 need -- ought to go on record again as to --
13 pertaining to that issue, as well as the issue of
14 the MOU with the DOE.

15 **DR. ZIEMER:** Let me comment, Jim. You may
16 recall at the last meeting, in fact, we in a sense
17 deferred doing that till we saw the extent to which
18 the contractor would be up to speed and perhaps
19 awaiting a little more definitive information on
20 what the staffing plan needs would be as seen by the
21 staff itself.

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

23 **DR. ZIEMER:** It's becoming clear certainly
24 that additional manpower or person power is needed,
25 and at some point if it's important to even go as

1 high as the Secretary, we may need to do that --
2 recognizing that we don't want Larry to end up in a
3 position of somebody viewing this Board as somehow
4 helping him leverage staff to the hierarchy. But on
5 the other hand, there are valid concerns about the
6 ability to get the work done, then we need to go on
7 record for that, so --

8 **DR. MELIUS:** Yeah.

9 **DR. ZIEMER:** And it may be that this is the
10 time to do that in some way, so --

11 **DR. MELIUS:** And just add to that, say -- I
12 don't remember the exact wording, but since this
13 Board is specifically charged with evaluating the
14 quality of the dose reconstructions being done, I
15 think --

16 **DR. ZIEMER:** Then that can be the --

17 **DR. MELIUS:** Yeah, that's the --

18 **DR. ZIEMER:** That can be the lever.

19 **DR. MELIUS:** Yeah.

20 **DR. ZIEMER:** Right. Okay. Roy DeHart has a
21 comment or --

22 **DR. DEHART:** As people in the medical
23 community are painfully aware, Federal legislation
24 passed several years ago becomes fully implemented
25 in April of '03. I'm referring to what is called

1 HIPPA, Health Information Privacy and Portability
2 Act. Is this program going to in any way
3 incorporate the HIPPA guidelines for the privacy
4 transmission of data electronically, verbally, and
5 how are we going to protect that since the
6 government has taken a very active role in this
7 matter?

8 **DR. NETON:** I believe Dave Sundin has taken
9 a look at that and he might be able to comment on
10 that.

11 **MR. SUNDIN:** We have looked at this act, but
12 our sense right now is it applies primarily to
13 health care providers and is designed to eliminate
14 some of the misuses of privacy -- of medially
15 confidential information for marketing and other
16 purposes. At least as we currently read it, the set
17 of covered entities does not include the agencies
18 that are doing the kind of work that we're doing.
19 So I mean the principles are certainly ones that we
20 subscribe to, but in terms of that Act actually
21 covering this program, our reading is it does not.

22 **DR. ZIEMER:** But Dave, you are at the same
23 time saying that we have the same level of
24 confidential protection that that --

25 **MR. SUNDIN:** Well, certainly the Privacy

1 Act --

2 DR. ZIEMER: -- provides.

3 MR. SUNDIN: -- itself is --

4 DR. ZIEMER: Right.

5 MR. SUNDIN: -- has some very serious
6 provisions about protecting that kind of
7 information.

8 DR. ZIEMER: Roy, does that answer your
9 question?

10 DR. DEHART: The concept of the application
11 of the principles of security is the point that I
12 was making. I knew that it doesn't fit in terms of
13 health care communities, but I think the privacy
14 issue is applicable here.

15 MR. ELLIOTT: If I could add a comment here,
16 we are working right now on a revision to our
17 routine use authority under the Privacy Act to
18 accommodate some disclosure needs that we need to
19 account for in order to provide information to
20 Congressional inquiries, to provide information to
21 DOE to request information on dose for these
22 claimants, and that will soon be published in the
23 *Federal Register*. And in that you will find the
24 description of security arrangements and
25 requirements that we have to meet under the Privacy

1 Act, and I think it will be very informing for you.
2 And we'll make sure when that gets published in the
3 *Federal Register* you're notified by e-mail and it'll
4 be also placed on our web site. Okay?

5 **DR. ZIEMER:** Let me ask either Larry or Jim,
6 what do you anticipate is needed for this Board to
7 make sure that we have full disclosure of conflicts
8 of interest ourselves as we look forward -- public
9 disclosures, disclosures here within our group and
10 so on? We -- at some point when we need to get
11 everything on the floor ourselves.

12 **MR. ELLIOTT:** As I mentioned in my opening
13 remarks earlier, as the Board's meetings proceed to
14 reviewing individual dose reconstructions and
15 reviewing SEC petitions, you all, as individual
16 Board members, know the financial disclosures that
17 you have made and the waivers that you have been
18 given. We will need at some point in time in the
19 next -- within the next meeting, perhaps, to
20 introduce yourself as a member of this Board, not to
21 talk about, in your introduction of yourself to the
22 public, what your financial disclosure statement
23 was, but to talk about your employment history and
24 perhaps explain in general details where you might
25 feel that you would need to recuse yourself, given

1 your waiver, the information. That's pretty much
2 the limit of what we envision the Board would have
3 to do at one of the next -- future meetings.
4 Certainly not to go into your financial disclosure
5 statement, not the OGE-451. We're not going to talk
6 about that. That is private for you and we need to
7 maintain your privacy in that regard. But we need
8 to have you introduce yourself, explain your
9 background and explain why you might find yourself
10 in a situation where you would have to recuse
11 yourself, just so the public would understand that.

12 **DR. ZIEMER:** And that might in fact be an
13 agenda item for say the next meeting so that we
14 don't get too far along before that actually is
15 done.

16 Other comments or questions for Jim? Yes,
17 Mark?

18 **MR. GRIFFON:** Switching gears a little bit,
19 I had a question on the -- I guess the priorities as
20 far as the scope of work for the subcontractor, the
21 site profile work. Are the -- ORAU task of working
22 on the site profile --

23 **DR. NETON:** Yes, yes.

24 **MR. GRIFFON:** -- database?

25 **DR. NETON:** Right. The priority --

1 prioritization was essentially the big three. I
2 mentioned the two, getting the computer-assisted
3 telephone interviews done because without those no
4 dose reconstruction can move forward. The
5 collection -- or the review of the DOE submittals to
6 determine which ones we can move forward with at
7 this time, and then request additional information
8 for those that are lacking sufficient data. And a
9 third issue is the dose reconstruction data
10 collection and research, site profiling. Those are
11 all conducted by a different group within the
12 subcontract team -- the contract team, so none of
13 those issues will slow down at the expense of the
14 other. I mean clearly as the site profiles grow
15 better, more dose reconstructions can move. But
16 there's a separate dose reconstruction team, as I
17 indicated, led by Bill -- or dose collection data
18 research team led by Bill Tankersley, with a number
19 of other support people, primarily in both ORAU and
20 Dade Moeller. So they are already actively looking
21 through these things. We've asked them to go
22 through the ORAU database where they have
23 information that may be useful to us, as well. If
24 that information can be sufficiently pedigreed,
25 we'll start using it.

1 To address some of Dr. Melius's earlier
2 concerns about the AWE's, we've made some pretty
3 good progress in those areas. We've identified and
4 we went down and did a data capture effort in a
5 vault at Oak Ridge and pulled out information on
6 about 15 or so -- I think we talked about this
7 before -- AWE's. We also picked up what I call a
8 spaghetti diagram or a flow map of where all the New
9 York operations AWE information ended up. It turns
10 out that most of those AWE's were uranium
11 facilities, which is a good thing. I mean they're
12 all mostly east coast operations and we believe that
13 -- there's a large degree of optimism on our part
14 that the Environmental Measurements Laboratory,
15 formerly the Health and Safety Laboratory, in New
16 York City has substantial holdings of those records.
17 We're planning a data capture review effort there
18 later this month or early November with our ORAU
19 contractor to review those records.

20 I think that this is going to be --
21 nothing's going to be easy on this project, but I
22 think there's some light being seen here as far as
23 availability of bioassay monitoring records. Most
24 of the AWE's were not in the radiation monitoring
25 business. They were sort of coerced into it because

1 of needs by the Department of Energy -- maybe
2 coerced is too strong a word, but brought into it
3 because of that. And they didn't have radiation
4 monitoring capabilities, so the EML, formerly HASL,
5 went out there and sort of served as the corporate
6 health physics organization for them to review their
7 program. So we feel fairly optimistic that we can
8 shed a lot of light on those issues in return.

9 **MR. GRIFFON:** I guess I was picking up on
10 something you said -- during your presentation you
11 said that ORAU -- you're bringing them in to start
12 to review some of those -- the data --

13 **DR. NETON:** That the DOE submitted.

14 **MR. GRIFFON:** -- you've got already to
15 determine the adequacy of it for --

16 **DR. NETON:** Correct.

17 **MR. GRIFFON:** -- your needs, and I just --
18 you know, I'll say this again -- I've said it at
19 every meeting, I might as well get it in early this
20 time. You know, just my fear of putting the cart
21 before the horse.

22 **DR. NETON:** Right.

23 **MR. GRIFFON:** If you -- you know, if you
24 start just taking the data you have from personnel
25 records and you don't have a good clear indication

1 of the site profile --

2 **DR. NETON:** Yeah.

3 **MR. GRIFFON:** -- you'll be making wrong --

4 **DR. NETON:** Let me restate that, and I think
5 what I really meant to say was that they will go and
6 the ones that can move forward just based clearly on
7 the data of record that the DOE provided us, if they
8 appear to be compensable based on those large doses,
9 we're not going to hold those up. There's no reason
10 to go and collect environmental exposure information
11 or medical X-ray. We'll just move those forward,
12 and that -- those are sort of on a prioritized
13 basis. No one would be moved forward without the
14 complete picture of the site profile. As we
15 discussed earlier, it means you need all four pieces
16 of information -- environmental, medical X-rays,
17 internal exposure and external exposure. Without
18 the whole picture you can't make a real accurate
19 dose determination to move forward. Those are going
20 to be hard.

21 **DR. ZIEMER:** Larry?

22 **MR. ELLIOTT:** I'm glad Jim mentioned that --
23 what we're doing in regard to going out and doing
24 data review, data retrieval, capture efforts on AWE,
25 but I also would want you to know that -- you know,

1 I have a number of staff here today, but a couple of
2 these folks are actually going to go up on the hill
3 to Los Alamos tomorrow and review records and
4 develop a data retrieval plan on some information we
5 think is very critical for the Los Alamos site, so
6 -- and this is just an example of one of the many
7 concurrent efforts that are going on as we're trying
8 to bring the contractor along. So we're not just
9 dealing with transferring information to the
10 contractor and telling them to go forward. We're
11 actually pursuing some of this ourselves at the same
12 time.

13 **DR. NETON:** Right. We're working hard at
14 this and we've actually -- until we get this
15 computer linkage up that has adequate security, we
16 have actually provided a hard drive that contains
17 ten gigabytes* of data to the ORAU contractor
18 they're loading on their own computers. So they
19 right now have not necessarily real time, but fairly
20 real time access to the same information we have, so
21 we established that linkage already.

22 **DR. MELIUS:** Just one -- while we're talking
23 about AWE sites, I think it would be helpful -- at
24 least for me and maybe for the other Board members,
25 to -- if for our next meeting or one of our next

1 meetings for NIOSH to provide an update on those
2 sites and how you're handling them. I don't think
3 we've really discussed them very much here and I
4 think -- you're obviously making progress, but it
5 would be helpful to get a bigger picture of how
6 those are being handled, given the large number of
7 claims.

8 **DR. ZIEMER:** Jim, are you suggesting maybe
9 just a table or a matrix showing the site and where
10 it stands in terms of progress on -- with the site
11 characterization, or --

12 **DR. MELIUS:** Yeah, particularly relative to
13 claims coming in from different sites, what are some
14 of the problem sites. I think -- you make enough
15 progress, that may change -- the picture may change
16 in the next couple of months, but I think it would
17 be useful just for us to have a better handle on
18 what's happening.

19 **DR. ZIEMER:** Let me also ask -- and if this
20 goes beyond confidentiality things for the contract,
21 why you can decline it. I'd just like to get some
22 feel for either Jim or Rich (sic) Toohey, the degree
23 to which the contractor will be able to get up to
24 speed to where they need to be to handle this
25 contract. Is this going to happen in a week, a

1 month? I'm not asking for a firm date, but some
2 kind of a feel for how that's going. It seems to me
3 there's going to be a lot of hiring that's going to
4 be done.

5 **DR. NETON:** I don't know how I can address
6 the specifics of that. It's an evolving process.
7 We're just receiving our first monthly reports. I
8 think they'll be on my desk when I get back, but
9 maybe Dick can give us a glimpse of what he
10 perceives the future to be.

11 **DR. TOOHEY:** I'll try. Obviously, as you
12 all know, this thing is huge. We anticipate about a
13 dozen hires at ORAU, mostly health physicists on the
14 dose reconstruction research end of it. Our
15 partners maybe also another dozen full-time hires.
16 The health physicists actually doing the dose
17 reconstructions are stringers, if you want to call
18 them that -- part-time employees who are already
19 under contract to our partners, and we have a
20 laundry list of about 90 of those people ready to
21 go.

22 Now, they have to be trained. And not just
23 in dose reconstruction, but also in Privacy Act and
24 conflict of interest and all these other equally, if
25 not even more, important considerations. The

1 training has to be to procedures, so -- and the
2 procedures, as Jim mentioned, are under development
3 with NIOSH review and input.

4 The contract says that we cannot do any work
5 or any dose reconstructions, I should say, until
6 NIOSH has approved our quality assurance program
7 plan, which is a 90-day deliverable. I hope to have
8 that in between 45 and 60 days, so that's not a
9 hold-up. We have interpreted that to mean this
10 triaging of the records and things like that can go
11 ahead, even before that plan's been fully approved.

12 As was mentioned, we've already got staff in
13 doing telephone interviews. And in one of those
14 fortunate coincidences, some of our beryllium --
15 ORAU's beryllium staff in the Colorado office became
16 available because with the transition in fiscal
17 year, they were a little short on funding, so I've
18 got experienced telephone interviewers, already ORAU
19 employees, coming into Cincinnati to start reducing
20 some of the backlog of CATI interviewers while we
21 interview and train the permanent people doing that.
22 So there's a lot of synergism going on here.

23 We expect to be able to actually start dose
24 reconstructions within a week or two, and some of
25 the ones that are the low-hanging fruit, clearly

1 compensable, a case who -- you know, 40-year-old
2 developed leukemia with 30 rem external dose. I
3 mean that's an easy one. We'll get those knocked
4 out.

5 The ones that are clearly non-compensable,
6 as Mr. Griffon mentioned, that's a little harder to
7 do because unless you've got a good site profile,
8 you can't even estimate the maximum possible dose.
9 But I would comment for some of the major sites, the
10 site profiles are pretty good. For instance, the
11 leukemia case controlled study that Health Effects
12 Research Branch funded between Hanford and Savannah
13 River, we got pretty good site characterization data
14 from that we can bring to bear. There's a whole
15 bunch of things on this.

16 My best guess is we will be fully ramped up
17 and hopefully cranking out at least 150 a week by
18 January 1st. We realize to clear the backlog we've
19 got to go beyond that, at least steady state from
20 the 8,000 that was part of the year, part of the
21 proposal would be 160 a week, roughly. We have to
22 get over 200 a week just to stay even, and to clear
23 the backlog it's got to be even more than that.

24 **DR. ZIEMER:** Is the clock ticking now?

25 **DR. TOOHEY:** There's a number of clocks

1 working on this. Generally, the answer's yes.
2 There's a 180-day clock from the time a claim is
3 received from DOL. There's a -- let's see, 30-day
4 clock once you've got all the information you need.
5 There's a 14-day clock to do the CATI once the DOE
6 dose records have been received. So we've actually
7 got a whole bunch of clocks ticking simultaneously.

8 Part of the contract was to, together with
9 NIOSH, develop a plan and performance measures for
10 clearing the backlog, and that's currently in
11 development.

12 **DR. ZIEMER:** Thank you. Jim?

13 **DR. MELIUS:** Yeah. Again, tell me if you're
14 not able to answer this 'cause of the contract, but
15 it seems to me that all these clocks or many of
16 these clocks are dependent on receiving complete
17 dose information or exposure information from
18 Department of Energy. And I assume there's some
19 ability to adjust the clocks to take that into
20 account, also, 'cause it could very well be that you
21 could ramp up and be able to do 200 a week or
22 something, but you're not going to be able to do
23 that if you don't have complete information.

24 **DR. NETON:** That's correct. I think Dick
25 alluded to the fact that it's a 180-day -- 30 days

1 after the -- all the information needed to do the --
2 once you've identified that there's sufficient
3 information, that's a 30-day clock.

4 **DR. TOOHEY:** Let me also mention that we do
5 have contractual obligation to inform NIOSH if we
6 are being delayed because of delays in getting the
7 data from DOE sites, and they're already tracking
8 this and we'll be taking that over and doing the
9 same thing, and advising NIOSH on the status of dose
10 requests site by site -- or I should say operations
11 office by operations office.

12 **DR. NETON:** As Dick mentioned, the backlog
13 of 8,000 is a somewhat different situation than once
14 they start taking the reins and moving forward with
15 the current plan instead of coming from Labor. We
16 can work all that out.

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

18 (No responses)

19 **DR. ZIEMER:** If not, thank you, Jim, for the
20 presentation.

21 We are a little ahead of schedule and I'm
22 now going to use this opportunity to follow up on
23 Dr. Roessler's suggestion, and that is to ask those
24 who are here as spectators and other support people
25 to identify themselves. And the way we'll do that,

1 I think this is an open mike. Rather than do a Tom
2 Widner, come right up -- I'm not going to do that,
3 but I'm going to pass the mike around and ask, for
4 the record, identify yourself and who you represent,
5 if anyone other than yourself.

6 **MR. BERMUDEZ:** My name's Joe Bermudez and I
7 work with the Laborers Health and Safety Fund.

8 **DR. ZIEMER:** You've met Jim.

9 **MR. CALHOUN:** I'm Grady Calhoun. I'm a
10 health physicist with OCAS.

11 **MR. HALLMARK:** I'm Shelby Hallmark. I'm the
12 director of the energy program and worker's
13 compensation at Labor.

14 **MR. SUNDIN:** Dave Sundin with NIOSH/OCAS.

15 **MR. PLATNER:** Jim Platner with the Center to
16 Protect Workers Rights, which is the research
17 institute of the building trades department.

18 **MR. KLEMM:** Jeff Klemm, SAIC.

19 **MR. NAIMON:** David Naimon with the
20 Department of Health and Human Services.

21 **MS. HOMOKI-TITUS:** Liz Homoki-Titus with
22 HHS.

23 **MR. WIDNER:** I'm Tom Widner from ENSR
24 Corporation, the project director of the Los Alamos
25 Historical Document Retrieval and Assessment Project

1 currently underway, working for CDC.

2 **MR. GREEN:** My name is Phil Green. I'm a
3 public health advisor with the radiation studies
4 branch at the National Center for Environmental
5 Health and I'm the project officer working with Tom
6 Widner on the LAHDRA project.

7 **MR. SCHAEFFER:** I'm Mike Schaeffer with
8 Department of Defense, Defense Threat Reduction
9 Agency, program manager of the nuclear test
10 personnel review.

11 **MR. KOTSCH:** Good morning, I'm Jeff Kotsch
12 with -- a health physicist with the energy
13 compensation group at the Department of Labor.

14 **MS. TOUFEXIS:** Rose Toufexis with the
15 Department of Labor.

16 **MR. GRIFFIN:** Jim Griffin, MJW.

17 **DR. TOOHEY:** Dick Toohey, ORAU.

18 **MR. KATZ:** Ted Katz with NIOSH.

19 **MS. GILBERTSON:** Tracy Gilbertson with
20 NIOSH.

21 **MS. GARCIA:** Dolores Garcia with Senator
22 Bingaman's office here in Santa Fe.

23 **MS. HOMER:** I'm Cori Homer and I'm with
24 NIOSH. I'm the committee management specialist.

25 **MR. VAZQUEZ:** Robert Vazquez with

1 Congressman Tom Udall's office.

2 **MS. ORTIZ:** Michele Jacquez Ortiz, state
3 director, Congressman Tom Udall's office.

4 **MR. SILVER:** Ken Silver, environmental
5 consultant here in support of Los Alamos Project on
6 Worker Safety, LA POWS. We kept them out late last
7 night, but some of the workers will be here later.

8 **MR. HENSHAW:** Hi, Russ Henshaw,
9 epidemiologist with NIOSH.

10 **MR. MILLER:** I think that -- can we open the
11 comment period now? Richard Miller, Government
12 Accountability Project.

13 **DR. ZIEMER:** Thank you, everyone. Since we
14 do need a brief break before our next presentation,
15 I think -- is that correct, Mark? You need a little
16 setup time and so on, and so we are going to go
17 ahead and take our break at this time. It's
18 scheduled as a 15-minute break. We'll probably take
19 at least 20 minutes. Let's reconvene at 10:15, so
20 we're recessed for now.

21 (Whereupon, a recess was taken.)

22 **DOSE RECONSTRUCTION WORKGROUP**

23 **DR. ZIEMER:** I'll call us back to order.
24 Earlier in the year we appointed a work group, a
25 subset of this Board, to serve as the dose

1 reconstruction work group. Heading that work group
2 is Mark Griffon, and Mark, as you begin your
3 presentation if you would, for the benefit of the
4 record and all here, identify the members of the
5 work group, as well.

6 **MR. GRIFFON:** All right. Yes, the -- I'm
7 representing the work group for dose reconstruction
8 review, and we have our members Roy DeHart, Gen
9 Roessler, Rich Espinosa, Bob Presley and myself, and
10 Jim Neton has been -- a NIOSH representative -- a
11 regular member of our meetings to give us some
12 guidance.

13 Just for background, the statute requires
14 that the Advisory Board review a certain -- review,
15 as the -- I think these are from our charge in one
16 of our initial documents we created -- review the
17 scientific validity and quality of the NIOSH dose
18 estimation and dose reconstruction efforts. So with
19 that in mind, this work group has been working in
20 the past couple of meetings on the -- how will we go
21 about selecting the cases that this group will
22 review, how many cases should we review, what is the
23 scope of the review, and also do we need -- how can
24 we go about getting independent contractors to work
25 with the Board on reviewing -- on doing the case

1 review.

2 And we met last night again to further flesh
3 out some of the -- in the last meeting we presented
4 a protocol which expanded on the scope of these
5 reviews a little further, and last night we met
6 again and we're now in the process of trying to take
7 what we've done as far as the scope and begin to
8 work it into an RFP where we can actually put it out
9 and get some bids in for contractors to assist the
10 Board in this audit function or review function.
11 And last night the group met and we went through
12 some of this -- some of the major items in the RFP.
13 We have a draft which -- I hope we can finalize a
14 draft tonight and share it with the full Board
15 tomorrow. Right now it's in a little too raw a
16 form, but the presentation I have up here is going
17 to outline the basic things that we have included in
18 this draft RFP.

19 **DR. ZIEMER:** Mark, if we get into details on
20 the RFP, is that going to require an executive
21 session of this Board?

22 **MR. GRIFFON:** Well, that -- I'll defer that
23 question a little bit. I know in discussions we've
24 had we talked about any discussions of budget might
25 require an executive session, and to that extent I

1 -- you know, like I said, we would have these drafts
2 ready tomorrow morning for the Board and maybe we
3 can consider that tomorrow morning as a...

4 **DR. ZIEMER:** Let me suggest the following.
5 If -- discussions of this type have to be done in
6 executive session. We did not announce in the
7 *Federal Register* that there would be an executive
8 session at this meeting, so if there is one, number
9 one, we need to make that known today for the
10 members of the public who are here. And number two,
11 if there is an executive session, what I would plan
12 to do would be to put that at the end of tomorrow's
13 session so that folks who are here from the public
14 do not have to cool their heels out in the hallways
15 while we have an executive session. So if we do
16 need to do that to review details on an RFP for the
17 work group activities, then we will do that as the
18 very last item of business tomorrow rather than at
19 the front end, if that would be agreeable to the
20 Board.

21 I think in fairness to the members of the
22 public and others who are here, since this was not
23 announced in the *Federal Register* that there would
24 be an executive session at this meeting, we would
25 need to put it at the end of the session.

1 **MR. GRIFFON:** I think that makes sense. I
2 don't know -- does any part of that have to be in or
3 only the budgetary discussion?

4 **DR. ZIEMER:** I believe only the budgetary
5 discussions. Let me defer to the staff here.

6 **MR. ELLIOTT:** Well, any monetary estimate
7 that you've derived and how you've derived it, such
8 as hours that you anticipate would be spent, those
9 kinds of informations are -- would be considered
10 proprietary at this point and would -- we would want
11 to protect it not to give unfair competitive
12 advantage, so yes, that kind of information would
13 have to be held separate from your presentation this
14 morning and held in executive session tomorrow
15 afternoon.

16 And I would add it's not only members of the
17 public, but we would restrict the attendance to that
18 executive session to the members of the Board and
19 Dr. Neton and myself, so the court recorder, the
20 writer/editor and the rest of the staff and the
21 public would have to recuse themselves outside this
22 meeting room.

23 **DR. ZIEMER:** So with that in mind, Mark,
24 please proceed then.

25 **MR. GRIFFON:** Sure. Okay. So just again to

1 review, we've had a couple meetings here. After the
2 last Board meeting we did have a -- we met via
3 conference call on the 9th and we discussed some of
4 these same issues, the RFP and some budgetary items.
5 The -- some of the discussion was that NIOSH
6 represent us on the role the Board would have in
7 the, quote, unquote, selection of contractors to
8 work with the Board, and I wondered if I couldn't
9 come up with a good word here. I mean NIOSH is
10 hiring this contractor and so the procurement
11 process is with NIOSH. We're trying to have a role
12 in defining the parameters, including the scope of
13 work, and how the bidders will be evaluated. And
14 this is coming -- this is the Board's input into
15 this process, if you will, I guess. So when I say
16 selection, we're not making a final decision on the
17 contractor.

18 On this conference call we did discuss
19 procurement processes, the options out there in
20 terms of sole source versus competitive bid process.
21 Those sort of issues were discussed. We discussed
22 the work group's role in the development of the RFP
23 in that we would have a key role in this so we could
24 basically develop the scope of work entirely amongst
25 our work group and certainly reviewed by the Board.

1 We discussed the contractor technical requirements,
2 including the conflict of interest issues, so
3 technical requirements including personnel
4 requirements, but also -- we certainly had lengthy
5 discussions on the conflict of interest issues and
6 whether we would actually include language in the
7 RFP or in the evaluation plan or in both, possibly
8 outlining potential conflicts and conflict of
9 interest issues. And then we discussed the work
10 group developing an evaluation plan.

11 The evaluation plan would basically be the
12 plan that was used to evaluate the bidders in this
13 sense, and the weights -- it would include -- we've
14 got some draft -- we've got one draft plan from a
15 previous contract, but it wasn't the dose
16 reconstruction contract -- another NIOSH contract --
17 where it outlined these sort of personnel,
18 technical, management, and we're adding in a field,
19 conflict of interest, and how those would be
20 weighted and how those would be -- certain weights
21 or points are assigned to each and then the bidders
22 are evaluated against that plan -- that evaluation -
23 - or with that evaluation plan in mind. And we're
24 redrafting something to that effect which also might
25 be ready tomorrow morning.

1 And then we also discussed Board
2 representation on the NIOSH review panel. NIOSH has
3 a review panel -- maybe Larry can describe this a
4 little better, the panel that reviews all the bids.
5 And we had discussed the options of an external
6 reviewer being on that panel, and I think that was a
7 viable option. I don't know if it's gotten strict
8 approval from NIOSH yet, but I think that was
9 something that -- that a Board member could sit on
10 that panel was -- I think that conclusion was made.

11 **MR. ELLIOTT:** Did that come from Martha?
12 Martha DiMuzio?

13 **MR. GRIFFON:** Jim, can -- Jim --

14 **DR. NETON:** Martha DiMuzio of our office
15 checked with the Pittsburgh branch office and they
16 did indicate I think, at a minimum, one -- one
17 outside person could sit on the Board. We're not
18 clear at this point what level of training would be
19 required to participate in a Board meeting, though.

20 **MR. GRIFFON:** And a couple of questions were
21 just raised about that, too, as far as one -- one
22 Board representative or -- would it be one or more
23 Board representatives could be on it, I don't know.
24 How would -- you know, could the Board select them
25 themselves and would that person be a voting member

1 of that panel. I think those are some discussion
2 items at the end of this which I think we all should
3 discuss.

4 **MR. ELLIOTT:** Did you want me to speak about
5 the evaluation plan? I missed -- you asked me to --
6 just the panel.

7 **MR. GRIFFON:** Just the panel.

8 **MR. ELLIOTT:** Well, I'm glad to hear that
9 there's been some resolution that a Board member can
10 serve on that panel. There is training that would
11 be required, we know that. We talked about that
12 before, that NIOSH staff are required to take
13 training in procurement procedures and review. This
14 panel would be something we would set up. It's not
15 a standing panel, so within staff we'd identify
16 those technical staff members who would serve on the
17 panel along with the one Advisory Board member, and
18 they would use this evaluation plan that you all are
19 coming up with as the criteria to evaluate the
20 various proposals. So we've worked hard with Mark
21 and his group to try to identify ways to involve the
22 Board, get the Board integrated into this whole
23 process, and I'm pleased that I see some resolution
24 here toward that end.

25 **MR. GRIFFON:** So the RFP development is one

1 thing -- one major focus of what we were discussing
2 last night. And this has sort of evolved into four
3 primary tasks for the RFP, and I think really at the
4 last meetings we were focusing on the first one,
5 which is review of a selection of individual dose
6 reconstructions. These next three have sort of
7 evolved from our conference call and also
8 discussions last night, and these include review of
9 selection of NIOSH site profiles, technical
10 assistance for SEC petition determination and review
11 -- that's a little awkward, but technical assistance
12 for the SEC petition determination. Another role
13 for this Advisory Board is we have to review all the
14 SEC petition determinations by NIOSH, and I think
15 there -- you know, down the line we may see a need
16 to call in for some expertise to assist the Board in
17 these reviews. I'll talk about each one of these a
18 little more in a second.

19 And then finally review of methods or
20 procedures used by NIOSH or the contractor for dose
21 reconstructions. And these are not -- as Jim
22 pointed out to me, these are not necessarily in
23 order. In fact, that last one we thought was
24 something that would probably be one of the initial
25 tasks for this contractor. Come on board, review

1 the NIOSH and the contractor procedures and
2 protocols, methodologies right up front to make sure
3 everybody's on the same sort of sheet of music. It
4 seems to make a lot of sense to me, rather than
5 waiting till 600 or 1,000 cases are done and then
6 finding out through some review processes that we
7 have some real problems with the procedures, the
8 methods that ORAU and their team is using, so that
9 was something that was added on, too.

10 In addition to the RFP development, we've
11 been working on developing this evaluation plan.
12 Part of that -- part of that certainly -- a big
13 piece that we're working with is the conflict of
14 interest component of that plan and how we will
15 evaluate conflict of interest. Wrestling with it is
16 the word I was looking for. That's the word.
17 Certainly working on that.

18 And then the final thing, which I hadn't
19 included on my slides, I guess, but you'll be --
20 discuss more in the executive session tomorrow is
21 we've worked up some very preliminary draft sort of
22 budget numbers on what this might encompass.

23 Just to go through those tasks a little
24 more, the first one, review of the selection of
25 individual dose reconstructions. If you haven't

1 been at some of these other meetings, we have -- I
2 might refer you back to the previous protocol we put
3 out which -- I don't know if it's available in the
4 back, but it's certainly on the web site. We talked
5 about selecting a certain percentage of cases and
6 for the first year we were looking at probably
7 around 200 cases. That was based on two to three
8 percent, which was a number similar to what the
9 veteran's program review ended up, around two and a
10 half percent, I think, of the cases.

11 Considering sort of three different levels
12 of review, a basic level, which would be much more
13 intensive; and advanced level, and then a blind
14 review. And a blind review would be where the
15 reviewing team wouldn't have the sort of input files
16 or any of the dose numbers that NIOSH or the
17 contractor generated. It would just go from the raw
18 data and reconstruct it from there.

19 The advanced review is above the basic
20 review in that the one example -- and I would refer
21 you back to the protocol 'cause it gives a lot of
22 little differences, but the one strongest part of
23 the difference is there's an administrative record
24 for each case, and I believe Jim -- make sure I get
25 this right -- at the top of the file, the data file,

1 will be the part that NIOSH or the contractor used
2 for the reconstruction. There may be other parts
3 that were not used to do the dose reconstruction.
4 In the advanced review we would then ask the
5 contractor to review the entire administrative
6 record, whereas in the basic review we would only
7 look at the parts used by the contractor or NIOSH to
8 do the dose reconstruction. That's one example of,
9 you know, just the differences there.

10 Task two is the review of a selection of
11 NIOSH site profiles. And the reason we added this
12 task, and we think this is an important task, is --
13 just from my comments earlier today, that the
14 concern that if the site profiles are inadequate,
15 then -- we really think the Board has to have a role
16 in assuring that these site profiles are adequate
17 and complete -- this notion of completeness of data
18 -- to make sure that when the dose reconstruction --
19 you know, you could have a great deal of personnel
20 external and internal dose information and no site
21 profile, and then you get a site profile that just
22 doesn't match up and something's not in line with
23 the personnel records. So we think that at least a
24 selection of site profiles should be reviewed.

25 One part that we're having trouble with in

1 defining the scope on this is just the issues on
2 access -- possible access to the DOE. We can see
3 already that we still -- we're still in negotiations
4 on the memorandum of understanding for NIOSH to get
5 access. Now we're asking for another contractor
6 potentially to come in and access DOE directly. I
7 personally think that's an important component of
8 this, just in terms of value added for this
9 independent review because if we're just going to --
10 to use the extreme example, if we're just going to
11 review the mathematics, I don't think we're going to
12 find great differences and we're just going to spend
13 a fair amount of money to do really -- not much
14 value added. Whereas if we have -- if we do -- we
15 can better check the adequacy and completeness of
16 the data being used for the dose reconstructions if
17 this contractor also has direct access, but
18 understanding that there's certainly some issues or
19 questions or hurdles to get over with that regard.

20 Another potential is that this contractor
21 would have access to site experts. And in the
22 contract for ORAU there's a section that talks about
23 the contractor working with site-identified experts
24 -- could be former workers, health physicists,
25 supervisors, line managers -- the gamut. And if

1 those are identified by ORAU then that team could
2 probably be re-interviewed or -- you know, assessed
3 -- accessed by this contractor, as well, without
4 really having issues of going on the DOE sites.
5 That may be another way to get at that. But that --
6 we're still wrestling with that and certainly would
7 ask for Board input on that.

8 I think there's one more slide and then we
9 can discuss some of these.

10 Task three is technical assistance for the
11 SEC petition determinations, and this is -- you
12 know, scope is undetermined at this time. You know,
13 part of the thing in wrestling with this is we don't
14 know how many SEC petitions might come in in the
15 first year. We don't know the breadth of these and
16 there's not even an SEC rule, so you know, this is
17 kind of up in the air, but we think that -- you
18 know, just looking down the line, I added this on in
19 and just thinking that at some point the Board may
20 need to call on these -- this expertise and it
21 certainly made sense. It's similar skills that
22 we're looking for so it certainly made sense as a
23 task to add into this -- into this work.

24 And the fourth one, review of methods,
25 procedures used by NIOSH and the contractor, and I

1 think I mentioned that, just the preliminary review
2 of their protocols and procedures up front before a
3 lot of cases get done.

4 The next steps we're hoping to make this
5 evening, if my working group -- my working group is
6 available again, to complete a draft of this RFP to
7 share with the Board tomorrow morning, as I said.
8 Also try to complete an evaluation plan -- a draft
9 evaluation plan. And I think we sort of -- we might
10 have resolved this representation on the review
11 panel issue already, but items for discussion now I
12 think are that, along with potential notification
13 lists. I was interested to hear Dick Toohey's
14 comment that there's some 90 -- I think he said 90
15 -- contractors, subcontractors, et cetera that are
16 already used up out of the pool of potential
17 contractors. And I think that -- this is why we
18 have this item on here. We're not -- I think if we
19 put an RFP out, we want to make sure that certain
20 people know about it.

21 And then finally discuss the budget. I
22 think that -- that will -- we've agreed we'll hold
23 till tomorrow's executive session.

24 And that's all we had unless anybody on the
25 working group -- did I miss anything?

1 **DR. DEHART:** If I remember correctly, we
2 actually will not develop the RFP. That will be
3 done by procurement. But we will have input in the
4 formatting or the draft of the wording.

5 **MR. ELLIOTT:** You're drafting -- in this
6 complete the draft RFP Mark's talking about, you're
7 drafting the scope of work.

8 **MR. GRIFFON:** Scope, I should have said
9 that, yes.

10 **MR. ELLIOTT:** That's the piece that you're
11 contributing to this bigger document called the RFP
12 which has a lot of boilerplate language.

13 **MR. GRIFFON:** And you're right, I should
14 have clarified that. Okay, and that's it, if any --

15 **DR. ZIEMER:** Okay, well --

16 **MR. GRIFFON:** -- discussions or questions.

17 **DR. ZIEMER:** -- why don't you go ahead and
18 sit down and you can answer from your chair. We
19 have questions or discussion. Let's start with
20 Henry over here.

21 **DR. ANDERSON:** Do you have any kind of a
22 tentative time line for accomplishing all of this?
23 I saw -- I mean for tomorrow. The time line is
24 pretty clear for what you want to deliver tomorrow,
25 but for the rest of this as to how soon the process

1 could move forward?

2 **MR. GRIFFON:** Well, I think we -- you know,
3 we know -- we're sort of working backwards, too. I
4 think we heard on our conference call that there is
5 probably going to be a 120-day period -- is that
6 right, 120 days after the bid goes out?

7 **DR. NETON:** Forty-five.

8 **MR. GRIFFON:** Oh, 45 -- a 45-day period?

9 **DR. NETON:** I'll have to clarify that.

10 **MR. GRIFFON:** Anyway, we need -- there is
11 quite a -- I mean even if it has to be posted, but
12 then -- then the time to actually get this
13 contractor on board, I think we're throwing around
14 120 days or so, but anyway, it's a fair length of
15 time. So we really see the urgency to get the RFP
16 out. And as I understood it, the critical
17 components that we need to finalize are this scope,
18 the evaluation plan and some sort of estimated
19 budget. And then I think we need to -- you know,
20 other -- other things which the working group can
21 continue to work on, like how we're going to select
22 cases and things like that, you know, that can sort
23 of be pushed aside for now -- unless it affects --
24 you know, unless it affects the scope. But I think
25 -- you know, unless it affects the scope, we're kind

1 of pushing it aside. We're trying to get a draft
2 RFP and evaluation plan done, you know, in maybe the
3 next couple of days. It might need some more
4 massage work, but you know, at least within a week
5 or so I would say we could probably complete it --
6 complete that process.

7 **DR. ZIEMER:** Let me ask -- okay, Jim has a
8 question.

9 **DR. MELIUS:** Yeah. I think I -- I do like
10 the idea of having the site profiles reviewed.
11 However, I'm -- and I understand the dilemma of the
12 balance between -- how do you check that the
13 exposure information used for an individual case is
14 complete is a daunting task and could take up a lot
15 of time and effort. At the same time, the site
16 profiles are sort of a living document. They're
17 going to keep more information -- they're never
18 going to be complete. As NIOSH learns more as
19 they're going through and their contractor reviewing
20 individual cases, they're going to obtain more
21 information and put into the site profile. So I'm a
22 little concerned that the review of the individual
23 cases -- if I remember from the last meeting -- does
24 not include any attempt to go back and review the
25 amount of exposure information made avail-- was the

1 exposure information made available for that
2 particular case, was that complete. The check of
3 completeness will be what's available in the site
4 profile, what's available from the records that are
5 included in the dose reconstruction for that
6 particular case. And I would still like some
7 thought given to is there a way of -- at least on
8 some sort of a sub-sample of going back and checking
9 individual cases, also, to make certain that their
10 -- the information obtained for their dose
11 reconstruction was complete, since -- you know. At
12 the same time I don't necessarily think it can be
13 done for all cases, but at least for some.

14 Now we'll be discussing -- I think later
15 today or tomorrow -- the site profile process, I
16 believe that's on the agenda, and maybe that'll
17 become more clear there. But I still am -- I think
18 that the greatest concern that we're going to hear
19 from people about their individual dose
20 reconstructions is that the information was
21 incomplete, something was missed about my site,
22 about my exposure information and so forth. And I
23 think it behooves us to have a strong component of
24 our review focusing on that issue. Now whether we
25 have to do that as a separate -- last meeting we

1 were talking about doing that almost as a separate
2 contract, a separate review given how much effort
3 would be required. I think that the approach you're
4 taking may allow us to do that as part of this
5 process by reviewing the site profiles. But at the
6 same time I'd like to see some individual case
7 review of that -- of that particular component. I
8 don't know where you are in terms of your
9 discussions, but it sounds like you've been
10 wrestling with this, also.

11 **DR. ZIEMER:** Well, Mark, aren't the blind
12 reviews intended in part to dig into that in more
13 depth and make sure that there's a completeness of
14 the dataset?

15 **MR. GRIFFON:** Yeah, that is part of the
16 intent with the blind reviews, and it was also
17 actually the advanced reviews we were trying to get
18 -- and I have the same questions that Jim has on
19 this. We were wrestling with where to draw that
20 line. But the advanced review also had a component
21 of comparing the site profile information against
22 the data used to do the dose reconstruction and, you
23 know, judging the adequacy of it for making a
24 determination. You know, I think we -- I'm not sure
25 how -- you know, we'll have to re-examine the scope

1 for the advanced review, but that's certainly
2 something that's been on my mind as we've tried to
3 wrestle with this scope language.

4 **DR. MELIUS:** I guess the example I'm
5 thinking of is the person who -- dose reconstruction
6 and then has questions about their particular work
7 process or task that they did for some period of
8 time that weren't included in the site profile. And
9 therefore what they believe to be their dose
10 reconstruction information wouldn't be in there.

11 Now presumably the NIOSH/contractor process
12 would be trying to get at that, also. But we're
13 supposed to be checking up on that part of the
14 process. So you know, we need to --

15 **MR. GRIFFON:** I think part -- I mean also my
16 hope on that was we are, in the advanced review --
17 or one of the reviews -- looking at the interview
18 process with the individual claimants. And you
19 know, I think if I were to review one of these cases
20 I'd say well, you know, this individual said they
21 were working on this process and had some concerns
22 about exposures to something and, you know, we don't
23 see that anywhere in the dose assessment. That
24 might raise a flag, you know, so we can ask if the
25 contractor was asking the right questions or looking

1 for the right information. That's an attempt anyway
2 to get where you -- you know, where you're talking
3 about.

4 **DR. MELIUS:** Yeah, but might that not be a
5 more -- a better check on the system and how it's
6 working than having another contractor review the
7 site profiles? 'Cause that's a huge task to do and
8 I think it would -- I'm not -- while it's tempting
9 in some ways, I'm not sure that you ever really get
10 your arms around it enough, given the amount of
11 effort that's available to be spent on doing that
12 and given the fact that those profiles are going to
13 be continually updated. So we're expecting them to
14 change. We never expect them to be finalized. If
15 something new or something that wasn't considered
16 important or people didn't think would come up now
17 comes up in terms of a number of cases and therefore
18 it has to be updated.

19 **DR. ZIEMER:** But nonetheless, I think we
20 could argue that you still have the responsibility
21 to review that. We cannot say we're going to wait
22 till the site profile is complete. So you have to
23 review what you have and say okay, have they made a
24 conscientious effort to get the information that's
25 needed to do an adequate dose reconstruction. Or

1 are their obvious holes in the site profile. You
2 probably will never be able to say that you have
3 every piece of information, but you might be able to
4 say are there obvious gaps that need to be filled in
5 order to do a conscientious dose reconstruction. So
6 at some point we have to look at that and say have
7 they gotten the right information or are there these
8 gaps. I don't know what else you can do. We cannot
9 wait for completion.

10 **DR. MELIUS:** Yeah, I wasn't arguing for
11 that. I'm just --

12 **DR. ZIEMER:** No, I understand you weren't,
13 but --

14 **DR. MELIUS:** The question is the balance
15 between the amount of effort that goes into that
16 versus the amount of effort that we put into
17 checking individual cases as part of our review.
18 'Cause again, I think the latter, the individual
19 cases are where these concerns are going to come up
20 from the claimants. That's where the complaints are
21 going to be or the --

22 **MR. GRIFFON:** Yeah, I guess I -- you know.
23 I agree with that. I guess I was looking -- I was
24 looking to do both, and I agree with your concern
25 about scope. We certainly discussed this last night

1 that -- and to review a site profile, you know, boy,
2 that could be -- that could be wide open
3 potentially.

4 The concern I have with the -- you know, I
5 guess the concern about the -- just relying on the
6 questionnaires and interview process and things like
7 that, you might have process information, but the
8 questionnaires that have been developed talked about
9 potential exposures to radionuclides, and I've
10 interviewed a fair number of former workers at these
11 projects and I'm not sure we're going to get a lot
12 of information about specific radionuclide exposures
13 relayed on those questionnaires, so you may think,
14 looking at that, everything's fine. But you may do
15 a more in-depth site profile investigation and find
16 out that there were a lot more transuranics in a
17 certain process than anyone ever envisioned, you
18 know, as an example I've used before.

19 **DR. ZIEMER:** Mark, it occurs to me that you
20 were able to move ahead pretty well once you had a
21 feel for how the dose reconstruction process worked
22 and how the information was put together. I'm
23 wondering if we won't have a better feel for how to
24 evaluate the site profile when we see what that
25 looks like. I have only an intuitive feel for what

1 that's going to look like, and Jim's going to help
2 us now.

3 **DR. NETON:** I just want to make a quick
4 comment to that effect. I think the development --
5 the degree of development of the site profile is
6 very dependent upon the individual case. You know,
7 some -- some -- so I think the Board really, in my
8 mind, would evaluate for that particular case was
9 the site profile sufficiently developed to make a
10 dose determination in light of the application of
11 our efficiency process. It's not that all cases
12 will be evaluated against all the data in the site
13 profile. Only those portions that are necessary to
14 be used to apply the efficiency process come into
15 play. So I sense we're going down a path where we
16 want to have this perfect site profile and apply it
17 to all the cases that come through it. I don't
18 think that's going to be the case. I think in
19 essence most of the cases will not necessarily
20 require the full-blown site profile development --
21 or a lot of the cases, anyway. So I think we need
22 to be a little bit careful about how much emphasis
23 is placed on the pedigree of the site profile versus
24 the extent that it was developed to actually
25 determine the dose for that individual claim. And

1 maybe it'll become a little clearer when we do
2 discuss some of the dose reconstructions this
3 afternoon.

4 **DR. ZIEMER:** And it's conceivable that a
5 site profile might be adequate for one case on that
6 site and inadequate for another case on the same
7 site, I would presume.

8 Roy, you had a comment? No. Jim?

9 **DR. MELIUS:** I think Henry has.

10 **DR. ZIEMER:** Henry, you're up.

11 **DR. MELIUS:** Then I'll --

12 **DR. ANDERSON:** Yeah, I just wanted to kind
13 of -- I see the issues we're dealing with are kind
14 of two levels. One, the site profile issue, is
15 kind of an infrastructure -- data infrastructure
16 issue and is the Board -- do we want to get into are
17 we capturing for subsequent use all the information
18 available at a site, that over time information
19 erodes and is lost and the best time to capture
20 historic information is now, not ten years from now.
21 That's one issue, and I think that's an
22 overwhelmingly large task, but we may want to look
23 at that. I think the individual reviews are going
24 to point out some of the holes, and as we go through
25 that I think that's going to be probably the way it

1 will be easiest to investigate the site on specific
2 data information.

3 It seems to me that a critical factor's
4 going to be the case selections for review. And I
5 think as Jim pointed out to me, one of the issues we
6 may want to have as a criteria is we need to review
7 when a individual raises an issue on an exposure
8 that either is verified or not verified, we need to
9 review. So we've heard NIOSH will be addressing all
10 of those issues. We need to say -- look at is the
11 contractor and has NIOSH addressed that individual's
12 concern appropriate or if we're using, you know, a
13 group of experts on site, are they, you know, going
14 to be able to -- if we were to investigate that --
15 confirm what the individual said that might then
16 lead to a different conclusion. So seems to me a
17 key thing is how the contractor and NIOSH responds
18 to some of the exposure concerns raised by
19 individuals, and that will be part of the record and
20 that may be -- rather than randomly selecting cases,
21 we may want to look specifically at those kind of
22 issues 'cause I would say that's where you're going
23 to have the greatest potential conflict that a
24 worker's going to say well, I told them about this
25 and it never appeared. And we need to know was the

1 decision made appropriate or not.

2 **DR. ZIEMER:** In fact I think you raise an
3 interesting part of the audit process and that is
4 how in fact does NIOSH or the contractor or both
5 respond to those issues that arise during the
6 personal interview process.

7 **DR. ANDERSON:** And see, those are the ones
8 that --

9 **DR. ZIEMER:** Not that we review the profile
10 itself, but how the profile was actually developed
11 tells you a lot.

12 **DR. ANDERSON:** I mean those are the things
13 that are going to build the profile.

14 **DR. ZIEMER:** I mean that's part of an audit
15 function anyway, is it not, to say how are they
16 developing the profile. Not just what's in the
17 profile, but how is it developed or what was
18 overlooked or what was the follow-up. Who else has
19 --

20 **DR. ANDERSON:** And maybe the assumptions
21 that were made --

22 **DR. ZIEMER:** Right.

23 **DR. ANDERSON:** -- will more than compensate
24 for the issue. So you know, how it was addressed --

25 **DR. ZIEMER:** Okay. Jim?

1 **DR. ANDERSON:** -- may well be fine.

2 **DR. MELIUS:** But there's also another group
3 of claimants that are going to be from claims made
4 from survivors that are going to have almost no
5 knowledge of the site or anything and are not going
6 to be able to raise these issues. So our audit
7 process also has to protect them and make sure that
8 every effort was being made to get complete dose
9 information, exposure information when they're able
10 to provide very little information to help NIOSH out
11 in being able to do so. And so I think that's
12 another part that we have to look at.

13 **DR. ZIEMER:** Yes, Mike?

14 **MR. GIBSON:** The Board's also still looking,
15 I think, at, you know, some potential -- how to deal
16 with conflict of interest issues with the dose
17 reconstruction contractor. What happens if a
18 claimant says I believe there's a conflict of
19 interest with this -- these people that's doing the
20 dose reconstruction process? Does their claim just
21 stay in limbo then or how is the -- how's that
22 question going to be answered?

23 **DR. ZIEMER:** Maybe Jim or one of the staff
24 people could answer that for us. Or Larry.

25 **MR. ELLIOTT:** He bounced it back to me.

1 Well, and Shelby Hallmark reminded me of this
2 earlier. I'm sure most of the Board remembers that
3 we talked about this at the last meeting, that there
4 is -- in the appeal process there's an opportunity
5 for DOL, in their adjudication of appeals, to --
6 claims through the appeal process, to remand those
7 back to us for further evaluation if new information
8 comes to light. Hopefully, in the example that
9 you're providing, Mike, we would recognize that
10 before it was sent out the door and we would deal
11 with it effectively. If the claimant -- before they
12 signed the OCAS-1 form they identified that I've got
13 an issue here with who did my dose reconstruction,
14 they make that aware -- make us aware of that, then
15 we would react to that and deal with that
16 effectively and remove that problem before it ever
17 got to an appeal.

18 **DR. ZIEMER:** Jim wants to add to that.

19 **DR. NETON:** I just was -- understood what
20 you were asking. As part of the -- we were talking
21 about the biographical sketches being attached to
22 the dose reconstructions so that a person would know
23 who performed it. Actually an option may be, and
24 we've discussed this, that at the time the dose
25 reconstruction is assigned to a dose

1 reconstructionist, that would be forwarded to the
2 claimant so they would know up front who was
3 actually working on their case or claim and at that
4 time be able to raise an objection. It makes some
5 sense to be open up front, rather than after the
6 fact realize who did it and then cry foul or
7 something at that point. So that may be an option
8 to minimize that sort of a problem.

9 **DR. ZIEMER:** Yes, Rich.

10 **MR. ESPINOSA:** How transparent is that going
11 to be? I mean is the claimant going to be -- have
12 the access to the guy's resume?

13 **DR. NETON:** Well, as we talked about earlier
14 this morning, the final details of how that's
15 conveyed to the claimant are still being worked out,
16 but it would be something to the effect of either a
17 biographical sketch or a bulletized version of his
18 work history, that sort of thing, that would be
19 attached to possibly a letter sent to the claimant
20 saying your case is now in the dose reconstruction
21 phase and here are the credentials of the person and
22 their work history that is evaluating your claim.
23 And at that point they could weigh in and make a
24 determination if that was a problem for them.

25 **DR. ZIEMER:** Okay. Other questions or

1 comments? Let me ask the Board as a whole, do you
2 feel that the tasks that the work group has
3 enumerated, basically the four primary tasks, covers
4 what needs to be covered? And I'm not -- by asking
5 the question I'm not suggesting that I don't think
6 it does. I'm just giving you the opportunity to be
7 sure that the scope of what they've talked about --
8 and obviously one of the tasks, at least the one on
9 the Special Exposure Cohort, remains somewhat
10 undefined till the rule's in place. But in
11 general, do you feel the task is sufficiently
12 comprehensive or is it too comprehensive or what's
13 -- give us some feedback. I think -- I'm asking --
14 feedback to the work group.

15 **MR. GRIFFON:** I guess we would also, you
16 know, given Jim's comment on the site profiles and
17 the scope that that would involve -- I mean I think
18 if we get this draft document tomorrow, the Board
19 might have a better sense, then we can get some more
20 specific comments on where -- where those boundaries
21 should be and, you know, how the individual dose
22 reconstruction reviews are going to differ from
23 these site profile reviews and maybe which -- which
24 one is more the focus of the contractor. You know,
25 maybe one's a lesser focus than the other, you know.

1 So maybe they don't have enough details to give an
2 opinion on that right now, but...

3 **DR. ZIEMER:** Does the silence indicate
4 everybody's comfortable or everybody's
5 uncomfortable?

6 **DR. MELIUS:** Yeah, I mean --

7 **DR. ZIEMER:** Jim.

8 **DR. MELIUS:** I'll say it for myself,
9 probably -- maybe for others, is that I think we are
10 comfortable and I thank the working group for
11 looking ahead a little bit and thinking about the
12 Special Exposure Cohort situation and other things,
13 rather than having us to scramble six months from
14 now or even a year from now to change the contract
15 around or whatever for doing that. I think maybe
16 after we've heard more about the site profiles today
17 and then when we see the document tomorrow, we can
18 wrestle some more with this issue of completeness of
19 records and how we include that in this process.
20 But to me that seems to be the major issue in terms
21 of the scope of work that we need to discuss a
22 little bit more. But I'm certainly pleased with
23 what they -- the scope that's laid out so far.

24 **DR. ZIEMER:** Any other comments? Does Jim's
25 comment represent a minority report or is it...

1 Well, let me ask it a different way. Does
2 anyone have a high level of angst with what the work
3 group is doing? If not, I think we'll proceed and
4 -- yes, Wanda. Okay, here we go.

5 **MS. MUNN:** I don't know if angst is the
6 right word. I'm having a little difficulty
7 determining where the level of detail and the level
8 of involvement of this particular Board ought to
9 fall. I see the items that the group identified and
10 think yes, those are good items, and how far into
11 that do we actually need to get. I hear Jim talking
12 about the level of concern the claimants are going
13 to have with respect to the oversight that we have
14 given. And I can't help but feel that we are always
15 in danger of trying to get too much detail into what
16 my perception of this Board's charge is. I hope
17 that we can keep in mind that we're trying to assist
18 both the claimant and NIOSH in their activities and
19 not be making things more difficult for either of
20 those in what we're doing. So I guess I feel a
21 little cautionary about how much detail we need to
22 be involving ourselves with.

23 **DR. ZIEMER:** Thank you for those comments,
24 Wanda. And if I might perhaps add to that that --
25 or perhaps comment on that, that -- and certainly

1 it's been the intent I think of the work group and
2 of the Board as a whole that we are primarily
3 meeting to fulfill our responsibility for assuring
4 the quality of the work that's being done by the
5 contractor and by the agency, that we are not to do
6 the work of the contractor and the agency. The
7 primary task of gathering the information and doing
8 dose reconstruction lies in their hands, and we are
9 not established to micro-manage that.

10 We do want to have a way, I think, to assure
11 ourselves of the quality of the work that's being
12 done, the validity -- if I might use that word -- of
13 the work being done, so that there is in a sense an
14 independent look that those for whom the judgment
15 has been made can look with some degree of
16 confidence, whether they are compensated or not, and
17 feel that there was fair treatment, that it's not
18 some government agency that is simply trying to hurt
19 the little man, as it were, or the little woman. So
20 we have a role there to assure quality of the
21 process, and obviously we're walking a tight line
22 between what it takes to do that well and what it
23 takes to not do the work of the agency and the
24 contractor. And I think Mark and certainly the
25 working group's well aware of that, so -- but that's

1 a good caution I think for us as we proceed to not
2 let this balloon -- a good word to use in this town
3 -- to balloon to the extent that we're doing the
4 work.

5 Yes, Leon.

6 **MR. OWENS:** I think it's important that we
7 keep in mind that credibility -- the credibility
8 that the workers have in this process, credibility
9 that they have that this Advisory Board is doing the
10 right thing, is maintained. There's a lot of
11 skepticism, as you all know -- skepticism based on
12 issues of the past. And I think that the more
13 transparent that we're able to make this process,
14 the better feeling that the public will have. I'd
15 like to commend the work group on what they have
16 done. I think that the scope of work is
17 appropriate. But again, I think that as we discuss
18 all these issues we have to keep in mind the
19 credibility of this Board. I think all of us would
20 want to have a product that we can be proud of,
21 whether a claimant is compensated or not. And I
22 think that we all would share in that. We want to
23 have this Board credible and we also want the
24 claimants to feel that their concerns have been
25 addressed and they've been addressed in a way that

1 is clear, that they can understand. It's not
2 confusing.

3 **DR. ZIEMER:** Thank you. And Mark, were you
4 about to say -- oh, okay. Next is Mike.

5 **MR. GIBSON:** I appreciate Ms. Munn's
6 comments, too, but I'd also just like to say that I
7 think if the government and the Department of Energy
8 had overseen their contractors correctly in the
9 beginning, there wouldn't be an Energy Employees
10 Occupational Comp Act, and I think that's why, once
11 it was established, it was important to remove the
12 dose reconstruction from the Department and to NIOSH
13 so that we can make sure that we have a true and as
14 close to valid dose reconstruction as we can.

15 **DR. ZIEMER:** Thank you. Any further
16 comments?

17 **MR. GRIFFON:** Can I just add -- before we
18 close out this session, there was one other thing --
19 discussion point there, and I don't know if it's
20 possible, but it might be worthwhile for us to get a
21 list of the 90 contractors that have already been
22 consumed by the dose reconstruction contractor. And
23 I mean this in all seriousness 'cause we've also
24 wrestled with the notion of availability of
25 appropriate expertise for this -- for this Board

1 contractor. And then just -- I don't know if we
2 have individuals -- if we want to do it -- set up
3 the meeting here or -- or with -- in some way get a
4 list of individuals to notify that there should be
5 an RFP coming down the line on this issue.

6 **DR. ZIEMER:** I'd like to suggest that you
7 develop that list just as you work with the -- I
8 don't think we need to develop a list. In fact, I'd
9 be a little bit concerned about doing it in an open
10 meeting. It gets close to discussing personalities
11 'cause then you have to say well -- what we don't
12 want is the idea that Oak Ridge Associated
13 Universities got the 90 best people and so we're --
14 you know, they got the 90 draft choices and so we're
15 into the second team or something. There's many
16 other good people out there and I think you'll
17 readily be able to develop a list of qualified
18 people. But probably best done as you work with the
19 RFP. I don't know how the rest of you feel about
20 that.

21 **MR. ELLIOTT:** Let me react to that. I think
22 it's -- what I hear Mark asking for is who's
23 currently on board so that we can identify who's
24 not. We certainly can get that and we have time to
25 develop that and get it to the working group, to the

1 Board, before the RFP's issued. And as we talked
2 with Mark in the deliberations of this whole
3 procurement process -- we walked you through, Mark,
4 and for the benefit of the Board -- that if we can
5 identify who should be made aware that this RFP is
6 now available on the street and ready for proposal,
7 procurement will send that -- make sure that a
8 letter goes to those people. So that's what we're
9 after here. We can come up with that list.
10 Procurement will send it out.

11 **DR. ZIEMER:** Okay. Have we completed the
12 discussion on this topic for now? And we will be
13 returning to it tomorrow. I'm just looking at
14 tomorrow's schedule for the moment to see where that
15 will go. I think -- huh?

16 **UNIDENTIFIED:** (Inaudible)

17 **DR. ZIEMER:** Right, but we have some fixed
18 presentations already tomorrow, and there is a Board
19 working -- Board discussion and working session
20 right after lunch, and that may be where it comes.

21 **DR. MELIUS:** Can I make one suggestion or
22 proposal? Not -- regarding another issue that I
23 think it would behoove us to find some time on the
24 agenda to speak about and that's this conflict of
25 interest issue. And given the time frame that NIOSH

1 has to work with this and given that some of these
2 issues are up in the air still, I think it might be
3 good if we spent a little bit of time tomorrow just
4 formulating some recommendations to NIOSH on some of
5 -- on what the Board would recommend in terms of
6 some of this transparency, what gets posted, what
7 kinds of information's available so that we've given
8 them a set of recommendations rather than reacting
9 to something they develop later and given time
10 frames and so forth. I think it'd be a better way
11 of doing it. So if we could set aside a half-hour
12 or something tomorrow to discuss that, I think it
13 would be good.

14 **DR. ZIEMER:** And again, Jim, let's plan to
15 do that during the working session and I'll ask you
16 to remind the Chair if the Chair is forgetful.
17 Sometimes I do have senior moments -- not often, but
18 now and then.

19 I also have been informed by counsel that we
20 probably cannot have an executive session tomorrow
21 because of the requirements -- legal requirements of
22 the Sunshine Act and the requirement for pre-
23 notification in the *Federal Register*. So it appears
24 -- I don't know if that's a final --

25 **UNIDENTIFIED:** (Inaudible)

1 **DR. ZIEMER:** Yeah. We're still trying to
2 find some way to get this done, but we're cognizant
3 of the need to do things properly in terms of the
4 requirements of the Sunshine Act, so it may be that
5 we will not be able to have the -- an executive
6 session tomorrow since it was not announced in the
7 *Federal Register*. That could change, depending on
8 what we hear back from whoever's checking with the
9 right people. But in any event, we will have the
10 opportunity to discuss the other portions after the
11 work group has a chance to work further on this.

12 Let me ask Cori or others, do we have any
13 housekeeping items we need to take care of before
14 lunch -- before we break?

15 **MS. HOMER:** Let me check. Just a moment.

16 **DR. ZIEMER:** I'm sorry?

17 **MS. HOMER:** (Inaudible)

18 **DR. ZIEMER:** Remind, folks, for the public
19 comment period for this afternoon if you wish to
20 participate, please sign up. That's mainly so we
21 can plan for the time accordingly. I know there are
22 some who do wish to comment and we would simply ask
23 you to sign up so that we are aware of how many will
24 be involved in that.

25 Do we have -- we have no formal luncheon or

1 lunch plans. People are on their own for lunch. Is
2 there information available on where the good spots
3 are?

4 **MS. HOMER:** Well, there is a map --

5 **DR. ZIEMER:** They're all good in Santa Fe, I
6 know, but --

7 **MS. HOMER:** -- at the front desk.
8 Unfortunately, there's no listing.

9 **DR. ZIEMER:** Okay. But there are many
10 places around the square here and close by,
11 including here in the hotel. I think many of you
12 have already scouted things out, so if you don't
13 know where to eat, you generally follow Bob Presley
14 or Roy. That's primary business when you get into
15 town.

16 In view of the fact that we're able to
17 recess a little early, let's plan to start up after
18 lunch a little earlier. Can we plan to be back at
19 1:00 o'clock? Shoot for 1:00 o'clock. Let's give
20 you 1:15. I know you're likely to get trapped by a
21 blanket trader in the square, so we'll give you --
22 let's say till 1:15, how's that? Okay, we stand in
23 recess till 1:15.

24 (Whereupon, a luncheon recess was taken.)

25 **DR. ZIEMER:** Let's begin the afternoon

1 session with one announcement, and that is that we
2 have definitely determined that we will not have an
3 executive session tomorrow, or today. There are
4 certain legal requirements that must be met in order
5 to go into executive session. We're not able to
6 meet those for this meeting, so we will give you an
7 update tomorrow on whether or not there's an actual
8 action required by the Board prior to even
9 scheduling a future executive session. So when we
10 get final word -- there's some e-mails going back
11 and forth with the proper authorities to find out
12 the rules of engagement for executive session, so we
13 definitely have to have one, but when and how has
14 yet to be determined.

15 **EXAMPLES OF COMPLETED DOSE RECONSTRUCTIONS**

16 So we're going to proceed with our agenda as
17 listed and we begin the afternoon with some examples
18 of completed dose reconstructions, and Grady Calhoun
19 and James Neton are going to lead us in that. Who's
20 going to start, Grady?

21 **MR. CALHOUN:** Jim's going to start.

22 **DR. ZIEMER:** Okay.

23 **DR. NETON:** Grady's name is first. There
24 was a tag-team effort. I'm going to start off the
25 discussion and then turn it over to Grady.

1 This is in response to -- I think at the
2 last Board meeting in Cincinnati -- a request that
3 we go over some examples of the completed dose
4 reconstructions, and I apologize to those who are on
5 the working group because we've taken a subset of
6 the ones that we've already discussed with the
7 working group, although these are of course de-
8 identified and somewhat simplified in nature because
9 of that, so they won't look exactly as you saw them
10 before. But nonetheless, I think the messages that
11 we want to point out are still valid.

12 In looking at these things -- we've talked
13 about this at a number of different meetings, that
14 there are several different types of data that can
15 be used to perform a dose reconstruction, and those
16 include anything all the way from individual worker
17 monitoring data to -- which is what the DOE would
18 send us, their TLD badge results -- followed by
19 worker data with allowance for missed or actually
20 undetected dose, which we call missed dose. And
21 that would take the DOE record and supplement it
22 with dose that could have been received by the
23 person because of the detection limits of the badges
24 and frequency of the urine samples and those sort of
25 things. So that's sort of another stratum that we

1 would look at.

2 The third category would be the co-worker
3 monitoring data, where we had neither of those types
4 of information above available and we would just
5 rely on the worker's colleagues, as it were, engaged
6 in similar activities at the site.

7 And then followed by workplace environmental
8 data where none of the above existed, which would
9 consist of either air sample results, area
10 monitoring surveys, area TLD's, thermoluminescent
11 dosimeters, those sort of pieces of data.

12 And then finally followed by just source
13 term data, how much was there and what's the likely
14 range of doses a person could have received based on
15 just being there and working. Those are -- that of
16 course would be the most uncertain dose estimate.

17 What I have today to talk about is four
18 types of -- four dose reconstructions that address
19 the first four categories. We've done one -- at
20 least one of those dose reconstructions for each of
21 those categories. We have not yet done a dose
22 reconstruction where we have relied solely on source
23 term data, although I suspect that we will.

24 And just a little introduction before we get
25 into it about the report itself. I didn't

1 distribute copies of the reports to the Board.
2 They're very -- fairly hard to de-identify and
3 redact all the information that would be required
4 for public dissemination because some of these are
5 fairly specific work activities. It'd be easy to
6 identify if we left some of this stuff in. But the
7 report itself has four pieces -- we tried to
8 standardize these reports, and the four categories
9 you see listed here are included in all reports,
10 which is an introduction, dose determination, the
11 information we actually used or didn't use, as the
12 case may be. And a summary of the dose
13 reconstruction itself.

14 We tried to keep these things reasonably
15 short, and by that I mean that in general we'd like
16 a dose reconstruction to be ten pages or less, if we
17 can. That's not been the case in some of these
18 things. I think the longest one we've written is
19 maybe 16 pages, but to give you a sense for how long
20 these things are, as far as volume. The idea was to
21 make it readable by the claimant and understandable
22 to the extent possible, but also to include enough
23 information that a health physicist knowledgeable in
24 these areas could go through and, with the
25 administrative record, determine if the dose

1 reconstruction makes sense and used valid concepts
2 and that sort of thing.

3 So the four cases that I'm going to go over
4 are somewhat going to follow this format that
5 follows the format of the dose reconstructions.

6 Okay. The first case we're going to talk
7 about is where we have the individual worker
8 monitoring data available, and Grady's going to
9 discuss that one.

10 **MR. CALHOUN:** Do the microphone shuffle
11 here. Okay. Can you hear me? Can you hear me now?
12 Good.

13 This one is -- this one's based on
14 information that we got purely from his individual
15 monitoring data provided to us from the Department
16 of Energy. This is going to be an underestimate of
17 the actual dose received to go along with our
18 efficiency process, and I'll try to highlight the
19 steps that we took in that effort.

20 Okay. Employment history, we -- like Jim
21 said, we took out all the sites, so he worked at a
22 reactor facility -- experimental reactor facility,
23 was a health and safety worker -- oh, I'm sorry, I
24 can do that here. This was a case where it was a
25 survivor, because the employee had passed. I did

1 the interview myself with the lady and found out
2 that his duties involved handling radioactive waste
3 and he was also involved in a clean-up after a
4 reactor accident and after several experiments.

5 The DOE reported dose was he had photon deep
6 dose of 22.6 rem. This is a whole-body dose as
7 reported by DOE. He had a shallow dose photon plus
8 beta of 28.1 rem. And his verified cancer --
9 verified through the Department of Labor -- was
10 chronic granulocytic leukemia. He was diagnosed at
11 40 years of age.

12 What I did first was just to run through the
13 process with just using the photon deep dose only.
14 I didn't look at any internal dose. I just focused
15 on external initially.

16 Per our external dosimetry implementation
17 guide, there's three different ranges, energy
18 intervals of photons. And associated with each one
19 of those energy intervals are dose conversion
20 factors that are used to convert photon dose --
21 whole-body dose to organ-specific dose. I chose the
22 greater than 250 keV energy interval, knowing that
23 that would result in a lower POC than using the 30
24 to 250 keV energy interval because this was an
25 underestimate, so my starting point was to

1 underestimate, so that's why I picked that one.
2 Chances are he was probably exposed to this, as well
3 as that other energy interval.

4 The dose conversion factors that I was
5 talking about vary, and so I used the very lowest
6 DCF so that multiplying that by the whole-body dose
7 resulted in the lowest dose to the red bone marrow,
8 and this again was an underestimate and that's why I
9 did that.

10 Okay. The information that we used was just
11 the reported deep dose recorded -- record from DOE,
12 employment dates from DOL, verified cancer from DOL
13 and a diagnosis date from the Department of Labor.

14 Based on the external dose alone, the
15 probability of causation was about 72 percent, so
16 I'm done. You know, we -- it didn't take a long
17 time, and what we do is to try to make this an
18 efficient process. And if we can get a case to be
19 greater than 50 percent in this little amount of
20 effort as we can, we're going to stop then because
21 there's no sense doing additional work to increase
22 that any further. Because once it's over 50
23 percent, it's in.

24 Now internal dose. There was internal dose
25 and there was records of internal dose. I didn't

1 use it, because just by going through the external
2 dose alone resulted in a POC high enough -- greater
3 than 50 percent, so I didn't even have to look at
4 the internal dosimetry implications of this
5 individual.

6 Any questions on that one before Jim goes
7 on? Yes, sir?

8 **DR. MELIUS:** Yeah. How will you keep your
9 records or a database on this particular dose
10 reconstruction? What would be -- for example, if
11 you were doing a fellow worker of that person and
12 were (inaudible), what sort of information would be
13 available -- and I think -- are you indicating that
14 well, yeah, you used a very conservative or an
15 underestimate of their dose so that if someone had
16 only worked there at a different time period or
17 whatever that -- I'm just curious how you're going
18 to --

19 **MR. CALHOUN:** Well, there's a couple of
20 different things that we can do. Now we are talking
21 about actually -- with the help of the contractor --
22 creating a nice table that can reference who worked
23 where, what kind of cancer they have. Even right
24 now, the way our database is set up, I can search --
25 like say this guy worked at ABC Company. Okay? And

1 I've got another guy who worked at ABC Company
2 roughly the same time period. I can search for ABC
3 Company. I can search by year, then I can look at
4 the sampling of those individuals who do have dose
5 information and we can do a co-worker comparison
6 based on that.

7 **DR. MELIUS:** Okay.

8 **MR. CALHOUN:** So we do have that capability
9 already. It could be better, but it's not bad right
10 now.

11 **DR. MELIUS:** Okay, that's what I was trying
12 to get at. Thanks.

13 **MR. CALHOUN:** Okay, and this is microphone
14 shuffle.

15 **DR. NETON:** Just to elaborate a little bit
16 on Grady's response, we have had discussions in our
17 early meetings with ORAU to establish what we
18 consider to be the research database, and that's one
19 vital component of it. 'Cause as Grady did
20 indicate, we can search now, but the reality is we
21 have very few cases. We intend -- without slowing
22 down dose reconstructions because dose
23 reconstructions need to move forward, we intend to
24 code all of the exposure information that we receive
25 from the Department of Energy, whether we use all of

1 it or not. It will be available in a database for
2 our use and potentially for future use as other
3 projects may need.

4 Okay. That was a fairly simple,
5 straightforward one. I have to say that's probably
6 about as simple as a dose reconstruction gets. You
7 just add up the record from the Department of
8 Energy, you don't even worry about missed dose or
9 potentially undetected dose, and the person appears
10 to be qualified for compensation. Yes?

11 **MR. ELLIOTT:** As you go through these, I'd
12 appreciate it if you'd tell the Board and the
13 audience an estimated number of hours spent
14 completing it. Just -- you know, if you can ball
15 park it.

16 **DR. NETON:** I'd like to couch that, though,
17 with a warning that we're on the learning curve here
18 and we expect that these things will go down, but
19 Grady?

20 **MR. CALHOUN:** I'd say with that first one it
21 probably took me -- once I had all the information
22 in front of me, not counting the CATI interview, it
23 probably only took 16 hours to get to the conclusion
24 that this was going to be a greater than 50 percent
25 POC. Now when you factor into it the amount of time

1 required to write the report and send it through
2 some review and some iterations back and forth
3 through that, I would say it probably took a week.
4 And that was a really, really easy one. I've done
5 several, and that one was very easy.

6 **DR. NETON:** I'd say 16 hours is a long
7 estimate. Now as we're going through them, I think
8 to actually take the data, enter it in and run the
9 PC calculation, I think it could be done in a couple
10 of hours or less and could get to that conclusion
11 very early on. And we're on the learning curve
12 here. It takes time to look at --

13 **DR. MELIUS:** Should we take the supervisor's
14 estimate and then the working guy's estimate --

15 **DR. NETON:** I'm going to switch gears to a
16 more complicated -- this is probably one of the more
17 complicated scenarios you're going to run against,
18 so you're going to see sort of a bracketing range
19 here of how complex these things can or cannot be.

20 This is a case where we actually had the
21 worker's data from the Department of Energy, but
22 they only provided us annual summary information,
23 the amount of external dose the person received
24 every year for a fairly long period of time.

25 In this particular case the claimant had --

1 and actually this is a survivor claim, as well; the
2 person is deceased, I believe -- three primary
3 cancers. So the person developed prostate cancer in
4 1997, followed by lymphoma in 1998, followed by
5 basal cell carcinoma in 1999. These are all primary
6 cancers. These are not metastatic from some other
7 site. They're all verified by the Department of
8 Labor to be primary cancers and were treated as such
9 in the analysis.

10 The person had a fairly long employment
11 history at a DOE fuel and reactor -- in DOE fuel and
12 reactor operations. He started as a patrolman in
13 reactor operations between '48 and '52; switched
14 over to being an instrument technician, mostly
15 reactor operations, between '52 and '80; and then
16 became engaged in fuel fabrication -- a fuel
17 fabrication facility between '80 and '88, although
18 there was a little bit of uncertainty about exactly
19 when he shifted full-time from around the 1980 time
20 frame from reactor to fuel operations.

21 This person also has a relatively high gamma
22 dose record of 37.1 rem. This is just the annual
23 doses provided by the Department of Labor on record.
24 The majority of the dose was from working in the
25 reactor area. And again, as in Grady's case, we

1 started off by assuming that this person was exposed
2 to high energy photons that were greater than 250
3 keV. Again, that's the most that would result in an
4 underestimate if it were any lower than that in
5 energy.

6 I will say that in this particular case -- I
7 think I'll talk -- I'll get into this a little bit
8 later, but in this case DOE never did -- has not to
9 this day provided the individual monitoring records
10 for the badges, and so in this particular case these
11 records were supplemented with information that was
12 available in the NIOSH epidemiologic program that's
13 been going on for about nine years. The health-
14 related energy research branch had some significant
15 -- most of the person's exposure information in
16 their archives, so that allowed us to move this case
17 forward.

18 There was a very low recorded neutron dose
19 on this individual. I think his total neutron dose
20 as reported by the Department of Energy was 80
21 millirem. And we need to discuss a little bit the
22 concept of unmonitored versus missed dose. Missed
23 dose is the badge -- the amount of exposure was
24 below the detection limit. In fact, after reviewing
25 the records at the facility that this person worked,

1 it was determined that the badge itself could not
2 measure neutrons below the average neutron energy
3 that were present at that facility. So in a sense
4 it was essentially an unmonitored dose for that
5 fission spectrum of neutrons that range from I think
6 .1 to two -- .1 to two MeV, something like that.
7 And even if they were detectable above the average
8 neutron energy, the detection limit of the badge
9 itself was stated in that time period to be around
10 50 millirem. So we've got a lot of potential here
11 for a person to have been exposed to neutrons and
12 not have been recorded.

13 So we went and did our homework and pulled
14 some data from the sites, trying to develop these
15 site profiles. It turns out Jack Fix* in 1996 did a
16 -- with others, did a study to evaluate the old --
17 monitoring capabilities of the old neutron films,
18 the -- what's known as the NTA films, Nuclear Track
19 emulsion type A films. He did estimate that even
20 when it was measured, it was under-reported by about
21 ten percent, which is not too bad. We could account
22 for that.

23 Also of significance is the relative
24 biological effectiveness that was used in this case
25 was ten. And if you remember way back from the

1 David Coker presentation back at the Denver meeting,
2 our relative biological effectiveness that we're
3 assigning varies and it can be as high as 20 for
4 fission spectrum neutrons.

5 So applying this Fix -- the Fix evaluation,
6 the study that was done, we were -- we were looking
7 to apply -- we knew what the person's gamma
8 exposures were and we wanted to develop some kind of
9 a ratio of what the neutron to gamma exposure was.
10 So, you know, based on so much gamma, what
11 percentage of that could have been a neutron
12 exposure. And the ratios of neutron to gamma ranged
13 anywhere from about .13 to .73, a fairly wide range,
14 depending on the area and the monitoring program and
15 a number of different factors. And the ratio also
16 was dependent upon the magnitude of the dose.

17 So what we adopted here was a distribution,
18 where we felt the best indication of the average
19 ratio of gamma -- neutron to gamma was .26, but we
20 assigned a distribution to that that ranged anywhere
21 from .13 to .73. So if you all remember that the
22 IREP program itself allows for a Monte Carlo
23 simulation to not just used a fixed point, so we
24 could sample the possible range of neutron exposures
25 this person may have experienced in his work

1 environment.

2 There were a number of claimant-friendly
3 assumptions imbedded in this analysis, and one is
4 that -- remember, we're ratioing the whole body
5 exposure gamma -- the neutron to gamma ratios. In
6 this particular case, though, we added some missed
7 dose to the gamma dose because not all the badges
8 had measurable results on them so we increased the
9 person's dose. The neutron to gamma ratio that we
10 used was based on that total reconstructed dose, not
11 the dose of record from the Department of Energy.

12 We also used the gross track counts from the
13 badges without -- the method that Fix used was
14 method one where it was using the gross tracks. We
15 didn't know what the background subtraction was so
16 we just assumed the gross tracks were representative
17 of total neutron exposure. And a couple of other
18 indications here. We assumed continuous exposure
19 from '53 to 1980, even though there were some high
20 gamma exposures during -- obviously we couldn't
21 differentiate between the two so we assumed that
22 this neutron exposure occurred throughout this
23 entire time frame, and that same thing applies to
24 1980. We applied the same ratio.

25 The dose conversion factors are not really

1 important in this study. I just want to point out
2 that we do -- we do use them in our analyses. And
3 as Grady indicated, there are certain dose
4 conversion factors that we use, depending upon the
5 exposure geometry of the person. So we've -- we're
6 sort of moving towards refining these dose
7 conversion factors, and for a patrolman we decided
8 that his exposure would be 25 percent from the front
9 to the back, 50 percent from -- rotationally around
10 the body, and 25 percent isotropic, meaning from all
11 directions. This is professional judgment that
12 we've applied in here, but we believe it to be -- at
13 least in our minds -- a fairly accurate depiction of
14 their exposure profiles.

15 In the instrument technician we've assume a
16 75 percent anterior-posterior exposure and a 25
17 percent rotational.

18 These factors affect -- make small
19 adjustments to the dose. These are not huge
20 adjustments that are made.

21 Okay. I don't want to belabor this too
22 much, but this is sort of a summary sheet that
23 describes what we did. We took the whole body dose
24 plus the missed dose and came up with a whole body
25 gamma dose to eventually come up with a total body

1 gamma organ dose. Then we took that total body --
2 whole body gamma dose, used the gamma to neutron
3 ratio and then estimated what the total neutron was,
4 even though his total exposure to neutron was
5 estimated to be -- or measured to be 80 millirem by
6 the Department of Energy.

7 This is just a pretty picture that shows a
8 lot of the work we go through. We've generated 106
9 of these printouts so -- to give you a flavor for
10 how complicated some of these can be. I won't
11 bother going over any of those. If anybody has any
12 questions on those later, we could talk.

13 So we ended up with 68 inputs into IREP for
14 the prostate, two radiation types with 30-plus years
15 exposures. Another 68 inputs for the lymphoma
16 cancer and 106 inputs for the skin cancer because
17 there were four radiation types involved in his
18 exposure scenario. The beta exposure is not
19 included in internal organ exposure where it is for
20 skin cancer.

21 And this just goes over briefly the skin
22 dose determination. The badge actually was capable
23 of differentiating between beta exposure and photon
24 exposure with an open/closed window, so we looked at
25 that and calculated what the skin dose was directly

1 off of the open window badge with some corrections,
2 and there was some indication in the person's file
3 that they did have a skin contamination incident at
4 one point, but it was not included in this analysis
5 because we felt that we had sufficient dose
6 information in the file to move forward and
7 determine probability of causation.

8 So we did at this point not proceed any
9 further with the additional dose information that we
10 could have, which would be to evaluate the person's
11 environmental dose, since there was a large fission
12 product release at this facility between 1945 and
13 1961. The person also had 44 individual
14 occupational X-rays during his employment history,
15 two of which were stereoscopic X-rays that tend to
16 be the large dose-givers, the ones that are
17 sometimes an order of magnitude higher than your
18 normal diagnostic chest X-ray. And he also, like in
19 Grady's case, had a positive urinalysis for some
20 transuranic materials, in this case plutonium and
21 uranium. And as I indicated earlier, the skin
22 contamination incident that he was involved with was
23 not included.

24 So we did end up using the annual dose
25 provided by the Department of Energy. However, we

1 supplemented those with radiological records
2 provided by the NIOSH epidemiologic study group, and
3 we also used site-provided information on the
4 history of the dosimetry program to augment our dose
5 reconstruction, and this is essentially the start of
6 our site profile information at this particular
7 facility -- for external exposures, at least.

8 So in summary, these are what the PC --
9 these are what the organ doses were determined to be
10 for the individual, and you see the individual PC's
11 over here. Now one quick question, if you're sharp
12 after lunch here, why we just didn't do the skin
13 dose estimate because that exceeded 50 percent. And
14 the answer to that is -- I'll head off the question
15 -- is that we started doing this thing well before
16 the IREP models were finalized. And in the early
17 IREP, basal cell carcinoma, that model was -- we
18 knew it was being re-evaluated, but yet we were
19 trying to move forward, and under the old model this
20 person would have been below 50 percent. Under the
21 new model they were above 50 percent. So we had all
22 of these done anyway, so we ended up not discounting
23 them. We just included them in the final report.

24 It's interesting to note that even with a 60
25 rem lifetime dose estimated to the person to the

1 prostate, the probability of causation is less than
2 50 percent, so this is an indication that prostate
3 cancer does require a fairly significant exposure
4 for compensation -- dependent upon age, of course.
5 Lymphoma was 24.

6 So if one adds all these together using the
7 formula that is in our rule to combine the
8 individual probability to come up with a total
9 probability of causation, this claimant's overall
10 probability of causation ended up slightly over 74
11 percent.

12 So I know that was complicated and long-
13 winded, but I wanted to give you a flavor for how
14 these things can go. And given that, we still
15 didn't even look at the person's internal exposures.
16 We could have lengthened this dose reconstruction.
17 I will say that several weeks at least were spent on
18 this dose reconstruction. A lot of that was
19 learning curves as obtaining the background
20 information, reading those profiles, that sort of
21 thing.

22 Are there any questions on this one in
23 particular? Or have I put you all to sleep with it?
24 Dr. Melius?

25 **DR. MELIUS:** How are you capturing some of

1 your sort of work rules or -- so for then getting
2 those to the contractor and in a way that allows
3 them to make an informed use of this information and
4 --

5 **DR. NETON:** That's a good point. We've
6 talked about that. We envision a series of
7 bulletins so that these things get disseminated to
8 the field rapidly so this cadre of 90 or whatever
9 people working in the field will have access to the
10 latest and greatest information. But those would be
11 assembled eventually and consolidated into technical
12 basis documents, white papers, positions papers, if
13 you will, that would document what those positions
14 are, and that's one of our big concerns is
15 consistency. That's one thing the NIOSH health
16 physicists will be looking for is consistency of
17 application of these concepts, you know, across the
18 board for the different work category. Good
19 question.

20 I believe we have a question from the
21 general audience. Is that -- do we entertain
22 questions from the audience at this point?

23 **DR. ZIEMER:** Yeah.

24 **DR. NETON:** Okay. Joe -- or --

25 **UNIDENTIFIED:** (Inaudible)

1 **DR. ZIEMER:** Would you go to your mike,
2 please, sir? And please state your name for the
3 record.

4 **MR. SHONKA:** My name's Joe Shonka. There
5 was an additional claimant-friendly assumption that
6 you didn't state, and that's ignoring the shielding
7 of anti-C's and other clothing for the skin dose.

8 **DR. NETON:** That's correct. I think in this
9 particular case the cancer was on either the neck or
10 the cheek, I can't remember the specifics, so we did
11 not include that. Although if it were on a location
12 that would have potentially been shielded, we would
13 have evaluated that. I'm glad -- thanks for
14 pointing that out.

15 **MR. SCHAEFFER:** Mike Schaeffer, Department
16 of Defense. What would you do with a particular
17 case where you arrived at a probability of causation
18 below 50 percent; however, the person had a history
19 of higher exposures, either through occupational
20 exposures in other industries or perhaps an atomic
21 test participant?

22 **DR. NETON:** Under -- the way the Act is
23 written, we would not include those exposures in his
24 dose reconstruction. The probability of causation
25 calculation only uses doses incurred at covered

1 facilities -- DOE facilities or AWE's, so we would
2 not evaluate that case for those exposures.

3 **MR. MILLER:** Richard Miller from GAP. Let
4 me ask you what would have happened if your
5 probability of causation in this case again came out
6 below 50 percent? You made a set of assumptions
7 regarding your ratio of your neutron to gamma -- I
8 think it was a .26 and then you created a
9 distribution there. Assuming the neutrons in this
10 particular case had a much higher relative
11 biological effect than gamma, for example, would you
12 have re-run -- what policy or -- what would have
13 been your approach? Would you have then said okay,
14 well, let's make it .50 or .76? What would you have
15 done in a case like that?

16 **DR. NETON:** That's a good question. The
17 concept here is -- and we talked about this before
18 -- that we keep pulling the thread on this claim. I
19 mean you just keep trying to find dose until you can
20 find no more dose to add to the case, and at that
21 point if that ends up being below 50 percent, that's
22 what it is. So we would not -- if this case came
23 out 40 percent, then we would go back and say okay,
24 let's look at the environmental dose, let's look at
25 the internal dose from the transuranic out-take,

1 let's look at the skin contamination incident. And
2 in fact if we had exhausted all those possibilities
3 and added in the medical X-rays and it came out to
4 be 40 percent, that's all we can do. There is no
5 more dose to find in that file. So your original
6 question about the neutron dose, we don't know any
7 more about that neutron energy spectrum, so in this
8 particular case I suspect that that distribution
9 would stand. If we don't know any better, we don't
10 know any more, so that particular distribution for
11 the neutrons, the gamma -- the neutron to gamma
12 ratio would be used.

13 **MR. MILLER:** Can you just explain -- where
14 did you get the .26 from?

15 **DR. NETON:** Okay. There was a -- Jack Fix,
16 et al had published an article -- it's actually a
17 report at their site -- that reviewed for gamma to
18 neutron ratio -- or neutron to gamma ratios at these
19 particular facilities that we're looking at, and
20 those ranged anywhere from I think .13 to .72. We
21 cannot make a judgment as to where that range fell,
22 other than the fact that -- and I didn't do this
23 dose reconstruction so I can't exactly pinpoint why
24 .26 was believed to be their best estimate -- there
25 is a reason behind it that is documented, but we

1 decided that .26 was our best estimate, but we would
2 allow the range to vary between .13 and .72 on a
3 sampling basis. So all of those possible ratios
4 were sampled, given a triangular distribution.

5 **MR. MILLER:** But just to be clear, you're
6 not picking the upper confidence interval, you're
7 picking -- you're picking some mean around that
8 distribution.

9 **DR. NETON:** That's correct. That's correct.
10 It's the best estimate of central tendency. It
11 might not necessarily be the mean, but that's
12 correct. We are -- we are using what we believe to
13 be a reasonable approach to this.

14 **MR. PLATNER:** Jim Platner, Center to Protect
15 Workers Rights. Oh, I'm sorry.

16 **UNIDENTIFIED:** Go ahead, Jim.

17 **MR. PLATNER:** I just wasn't clear whether
18 you're -- you were saying that you're trying to sort
19 of accelerate processing for ones with the -- with
20 high exposures. Is it simply accelerating the dose
21 reconstruction for those cases or is there some sort
22 of triage of claims so that you assess first the
23 high dose case?

24 **DR. NETON:** It's sort of both, actually. I
25 mean if we can -- if we find a claim that has --

1 appears to have a very high dose and looks like a
2 candidate where one can just add up the dose of
3 record and move it forward, we'll do that. So it --
4 we've been triaging at this point primarily because
5 we don't have -- we didn't have the resources and we
6 wanted to get some experience with these claims.
7 But as ORAU goes through them, we've talked about
8 this where we need to get back to starting with
9 claimant one and moving through and looking at the
10 DOE data, evaluating it and seeing if we can do
11 something and requesting information. It's only
12 fair. Those claims have been sitting there longer.
13 But also to be compassionate and fair, people that
14 can be moved through the system with -- I don't know
15 if it's a couple of hours or 16 hours, it depends on
16 -- a matter of debate between myself and Grady -- we
17 need to get those out the door, too, so it's really
18 a combination of both of those things.

19 **DR. MELIUS:** Any way of -- with respect to
20 estimating work time, if you had had to do the other
21 -- the internal dose, some of the other things you
22 didn't have to do for this particular case, about
23 how much longer would it have taken? Any idea?

24 **DR. NETON:** Of course that depends, but
25 internal doses can be difficult. Assuming we had

1 the full record on the person for his internal
2 monitoring, I would say another week or two on that
3 case. But we will gain some efficiency in that once
4 the site profiles are there. The analysis itself is
5 not that difficult. It's actually gaining the
6 expertise and knowing what to do with the data,
7 which models to run, that sort of thing. So it's a
8 difficult determination.

9 Okay. Now I'm not sure which one is next
10 here.

11 **MR. CALHOUN:** Let's click it just to make
12 sure.

13 **DR. NETON:** Oh, that's mine.

14 **MR. CALHOUN:** Oh, that's you.

15 **DR. NETON:** I didn't think I was totally
16 inefficient in arranging this thing. This just
17 follows those three -- those four bullets that I
18 talked about earlier so it just sort of fell out
19 this way.

20 This is a dose reconstruction where we had
21 no monitoring information for the worker. In fact,
22 this is a dose reconstruction representative of an
23 Atomic Weapons Employer. It's one that we've
24 completed. This person was employed at an AWE, a
25 uranium facility, in fact, and again a fairly long

1 work history. This is a survivor claim, as well, I
2 should point out. The person worked there from 1940
3 to 1980. It was never really determined by Labor
4 through contact with the facility the person worked
5 there. Employment was actually verified via
6 affidavit, which is one means the Department of
7 Labor uses to verify eligibility in the program.

8 The person died of esophageal cancer in 1986
9 and upon interview with the survivors, they were
10 very unaware of the specific work activity of this
11 claimant. All they knew was the person went to work
12 at this facility and came home dirty, in coveralls
13 and apparently worked in a fairly messy operation,
14 which would rule out the fact that he worked in an
15 administrative area or something like that. He was
16 a production-type worker. So that's about all we
17 really knew starting this claim.

18 We of course asked the Department of Energy
19 to provide us some type of information on this and
20 we received very little. The Office of Worker
21 Advocacy provided some information, which consisted
22 of contracts and contract amendments with this
23 facility, which established that the employment
24 history for covered employment, at least at this
25 facility -- and some idea about what they were

1 doing. We had some technical progress reports.
2 There was a post-decontamination survey done on the
3 facility I believe in around 1960 time frame, and a
4 Former Utilized Site Remedial Action Program, the
5 FUSRAP program, actually became involved with this
6 site and did some fairly decent documentation about
7 what contamination levels were around -- I think it
8 was '60 or '61.

9 As I mentioned, we did conduct an interview
10 with the survivor, learned very little, could not
11 describe any of the work activities -- I essentially
12 went over these bullets -- and then also did believe
13 that all co-workers were deceased. We always ask
14 that question. It's the last question on our
15 interviews, can you give me names of any co-workers,
16 and they were unaware of any of this person's co-
17 workers that we could talk to to find out more about
18 the process.

19 So we started a search for data. Again,
20 this is a co-worker data, so we tried to find
21 someplace where we could hang our hat on to at least
22 give a bracketing range for doses at this facility.
23 The company was no longer in business. They no
24 longer exist. In fact, it had been turned into a
25 school, I believe, after it ceased operations. The

1 company handling retirement accounts could not
2 describe what happened to the AWE. So our approach
3 was to go -- look at the DOE web site -- and again,
4 we talked about the progress reports, the contracts.

5 We did contact -- this was an extrusion
6 plant or at least purported to be an extrusion
7 plant. They were trying to take the uranium billets
8 or whatever and turn them into rods. So there was
9 only one existing AWE extrusion plant still in
10 existence and that is the RMI facility in Ashtabula,
11 Ohio. They're undergoing remediation at this point.
12 We contacted them, hoping we could maybe get a range
13 for similar facilities. You know, what type of
14 activities went on there. But it turns out that
15 when we did the search at this Atomic Weapons
16 Employer, they had monitoring information for the
17 AWE we were looking for. Somehow that process was
18 transferred, through several other plants -- through
19 a Michigan facility -- and ended up in this
20 Ashtabula facility. So they actually had dosimetry
21 records for 1959 and 1960 for this particular
22 facility where the claimant worked. This was a
23 really good find for us. We were pretty happy about
24 that.

25 Also in reviewing these external dosimetry

1 reports, we noticed that additional documentation in
2 the files indicated that the Department of Energy
3 Environmental Measurements Laboratory had taken some
4 bioassay samples. So we contacted the Department of
5 Energy Environmental Measurements Laboratory, and lo
6 and behold, they had about 200 pages of bioassay
7 samples for this facility, as well. So we felt like
8 we were onto something and, given that type of
9 information, we might be able to do a dose
10 reconstruction for this worker based on co-worker
11 data.

12 Above and beyond that, in looking at the
13 dosimetry reports, the reports were sent to the
14 radiation safety officer in 1959 and '60 and we
15 recognized that he's still an active member of the
16 Health Physicists Society, so we called him up and
17 asked him if he'd be willing to be interviewed to
18 discuss the operations in this time frame at this
19 facility, and he did.

20 So during this interview we learned a lot of
21 interesting things, and some of them are indicated
22 here. He indicated that it was an AEC project, that
23 the AWE employed about 12 technicians and
24 administrative personnel only at that facility, so
25 it was a fairly small operation, subset of the

1 plant. It was actually a metallurgy laboratory only
2 and the general plant personnel did not migrate
3 through that operation. He did believe that all
4 technicians on this job site were monitored, and in
5 fact we did find monitoring results for 12
6 technicians for those couple of years. He did state
7 that all technicians wore coveralls and lab coats,
8 and that he did not think that in this particular
9 operation -- this was a fairly clean metallurgy
10 laboratory. They were looking at process and not
11 production. They weren't actually making these
12 rods. They were actually investigating the process,
13 and this was not typical for these people to become
14 dirty doing their work. There were other facilities
15 at the site that that was clearly the case, but not
16 in this laboratory.

17 Okay. A few more things that we learned was
18 all the extrusion, as I mentioned, took place at
19 different facilities, so they never really extruded
20 any rods at this facility. And in fact, that was
21 all done at this World War II Air Force aluminum
22 extrusion facility in Michigan at some point. The
23 AWE was sold in '61 and operations were moved to
24 other facilities, and I think this was the time
25 frame it became a school. It was -- a

1 decontamination survey, though, was done at that
2 point and we have that data, so we felt pretty
3 comfortable we knew the whole story.

4 So in looking at the film badge results we
5 obtained from the records at the RMI facility, none
6 of the film badge records were assigned to the
7 claimant that we were looking for. Again, they were
8 only for a two-year period. So what we thought was
9 -- we realized that the process didn't change much.
10 We knew the process didn't change much over the
11 whole period of operation that it ran those 12
12 years, so what we attempted to do was to find out
13 what was the highest external exposure at that
14 facility to the highest employee, so we took the
15 highest annual dose for any monitored employee over
16 those 11 years, which resulted in an upper estimate
17 of 550 millirem per year being assigned to the
18 worker -- or to the claimant.

19 And what this -- these two graphs show a
20 sort of before and after picture. These 24 numbers
21 here represent the 24 individual badge reads we had.
22 This is -- there were 12 people monitored for two
23 years, so we had 24 annual doses. So this is the
24 highest annual dose of any particular year was
25 somewhere around 375 millirem, and you see a lot of

1 people received nothing and much lower than that.
2 So we went back in and added a missed dose into
3 these badges. These were annual summaries and we
4 knew the badge exchange frequency and the detection
5 limit, so we added back in a potential missed dose
6 and we determined that the highest monitored
7 individual for any given year was 550 millirem. So
8 what we did was we assigned that 550 millirem for
9 every year that the claimant worked at that
10 facility, even though we weren't sure or had any
11 evidence that that person received that exposure.

12 The internal dose -- again, we had a lot of
13 fairly complete -- we believed complete monitoring
14 records for that facility that were taken by the
15 Environmental Measurements Laboratory, which is a
16 pretty well -- pretty reputable laboratory within
17 the DOE system, and again no record of that employee
18 ever having been sampled at that facility.

19 The samples were not routine samples. They
20 were not on a routine program, but they did cover a
21 majority of the time period that these people were
22 working there. The first several years were fairly
23 consistent, indicative of a -- possibly like a
24 chronic, low level exposure, followed by a couple of
25 incidents in 1960 and 1961 time frame. So we did

1 model the exposure as a chronic, followed by two
2 acute exposures, again using the highest individual
3 from each exposure scenario, so we took a composite
4 and took the worst case internal exposure we could
5 get from the highest individual in every particular
6 scenario. And in doing that, the maximum annual
7 esophageal dose was 16 millirem to the claimant's
8 esophagus. That is sort of indicative of the fact
9 that uranium does not concentrate in the esophagus,
10 so the metabolic model indicates that uranium
11 doesn't concentrate there so it's not surprising
12 that we assigned a fairly whopping intake to this
13 individual. I think we ended up assuming that the
14 person had inhaled seven grams of uranium during
15 their work history at that facility, which is almost
16 impossible to accomplish, but we did demonstrate
17 that even given that worst case assumption, the dose
18 is fairly small to the esophagus.

19 So, we took the exposure period to be from
20 the beginning of the first day of the award of the
21 AEC contract to the end of the date that the
22 facility was decontaminated, so we took that 550
23 millirem external, those 15 millirem internals and
24 used them -- applied them to the claimant from --
25 between these two time periods and ended up with an

1 upper bound of what this person could have possibly
2 been exposed to as a result of his employment and
3 ended up resulting in a probability of causation
4 value of around 15 percent. So we're fairly
5 confident that this particular claimant, based on
6 co-worker data, did not receive anywhere near an
7 exposure that could have resulted in a 50 percent
8 PC. And in fact, even if his exposure were five
9 times what we estimated, the probability of
10 causation would be 48 percent. So this is an
11 example of how we can go about using co-worker data
12 -- in this particular case, a worst case assumption
13 -- move this claim forward without really having
14 individual monitoring data available.

15 I think that's it. Are there any questions
16 on that one? It's a fairly interesting one,
17 actually. We were very happy to find the AWE data
18 that we did. Richard?

19 **MR. MILLER:** When you did this particular
20 project -- this was an extrusion facility -- did you
21 assume that this was soluble or insoluble forms of
22 uranium? What was the assumption on that?

23 **DR. NETON:** I don't recall at this point,
24 but we took what would be the worst case exposure to
25 that organ, and I'm --

1 **MR. MILLER:** But I mean it changes your dose
2 calculation significantly if it's -- right? If it's
3 an oxide or a -- versus a --

4 **DR. NETON:** Whatever would have been the
5 most claimant-beneficial approach to use, and I
6 don't recall whether it was soluble or insoluble
7 form at this point. It more than likely would make
8 very little difference because it just does not
9 concentrate in the esophagus itself. If this were a
10 kidney exposure, kidney dose or something, it would
11 make a difference, but the esophagus -- the only
12 dose that the esophagus receives is actually from
13 the uranium in the blood that travels through the
14 organ itself, so if it's soluble, the migration time
15 through there would be fairly quick and it would be
16 excreted or concentrated in the kidney, so -- I want
17 to -- I'm guessing that it was soluble, but I'd need
18 to check the dose reconstruction to confirm that.

19 **MR. MILLER:** Okay. And then secondly, just
20 out of curiosity, when you did your analysis of this
21 in terms of the materials that ran through this, did
22 you do any investigation about the origins of the
23 uranium that came into the facility?

24 **DR. NETON:** The origins of the uranium?

25 **MR. MILLER:** Yeah, I mean 'cause there's

1 some of the uranium that came into these facilities
2 that ran through the recycle program and some of
3 them --

4 **DR. NETON:** That's correct.

5 **MR. MILLER:** -- did not run through recycle,
6 and that's why I'm asking.

7 **DR. NETON:** We did not do a detailed
8 investigation. We had no indication that any of
9 these things had been through the recycle program.
10 But in reality, the doses are still going to be very
11 small to the esophagus from that half-life.

12 **MR. MILLER:** But -- but -- but in terms of
13 when you're doing the site profile for this AWE, it
14 would seem to me an awful lot of -- because the
15 recycle program began in roughly 1957, you know, and
16 there were hundreds of thousands of tons of material
17 that did run through this program because DOE didn't
18 want to waste the material, I just didn't know what
19 point you decide you're going to start entering that
20 kind of inquiry into your analysis.

21 **DR. NETON:** Right. I can say that we
22 discussed this on this particular case. We're well
23 aware of the issue that you raise. And I cannot
24 exactly recall, I'd have to go back to the paperwork
25 to determine what reason we used -- why this was not

1 relevant in this particular case, but I know that we
2 talked about it in the dose reconstruction itself.
3 I'd have to go back to the original records to look
4 at that to see what we actually decided. But again,
5 we -- this person had inhaled a theoretical seven
6 grams of uranium. If that material were
7 contaminated with a thousand parts per billion of
8 plutonium or something of that nature, it would make
9 it almost to the third decimal -- to the first
10 decimal point maybe in the dose. I'm not -- it
11 would be a very small contribution. And I think we
12 have those calculations somewhere. I'd need to go
13 back on that.

14 Any other questions? Okay, we need to move
15 on.

16 **MR. CALHOUN:** Okay, I'll try to do this one
17 quicker than 16 hours. This one's going to be
18 pretty much the opposite of what I did before. As
19 you saw before, I did an underestimate of the dose
20 received. This one's going to be an overestimate of
21 the dose received, and we're going to be using
22 primarily workplace monitoring data and
23 environmental data.

24 Okay, here's the deal. This is one that I
25 actually dealt with, too, from the beginning to the

1 end. This person worked as an accounting specialist
2 from 1992 to 1997. Primary duties were bookkeeping,
3 banking, billing, preparing financial statements,
4 things like that -- administrative completely. Work
5 location required no dosimetry. I actually did the
6 telephone interview with this person and there was
7 no entry into the radiologically controlled areas at
8 any time during her employment.

9 Okay, DOE reported dose, there is none. She
10 wasn't in the area where dosimetry was required,
11 therefore there was no dose report provided by the
12 Department of Energy.

13 Department of Labor verified chronic
14 myelogenous leukemia, and she was diagnosed at 53
15 years of age. This is prior to the end of her
16 employment period.

17 So I don't have any data to go by as far as
18 occupational exposure that would be monitored by
19 DOE, so I go to environmental report data. So what
20 I did is went back through the environmental reports
21 for these sites -- this site and looked at the TLD
22 doses, got the very highest TLD dose for the period
23 that she worked and assigned that to every year of
24 her employment at that facility up until the point
25 of diagnosis. The TLD station that I looked at was

1 in between her work station and what would be
2 considered the source term of the radiation. I put
3 in here this is an overestimate.

4 Now you've seen before I used the greater
5 than 250 keV photons. In this case, since I'm doing
6 an overestimate, I used the 30 to 250 keV energy
7 interval because this would result in a higher
8 probability of causation, so all the external photon
9 dose that we applied I assumed was in this energy
10 interval.

11 Did not use a DCF at all. Dose conversion
12 factors in most cases, and especially for this one,
13 this would be to the red bone marrow, are going to
14 be less than one, so you're going to take your whole
15 body dose, multiply by a number that's less than one
16 and come up with even a smaller dose. In this case
17 did not use that because it's an overestimate.

18 Now as far as internal dose goes, there was
19 a whole series of perimeter air monitoring data that
20 was taken throughout this facility. Now this one
21 did take a long time because I ran through all
22 different kinds of scenarios, and specifically to a
23 question that Richard asked, I went through fast
24 solubility, slow solubility, went through several
25 different radionuclides to try to come up with the

1 very highest dose to the red bone marrow. Turned
2 out that the activity that I used -- and those of us
3 who have been in monitoring situations before know
4 this is a very significant overestimate -- I used
5 gross alpha activity and assumed that all that was
6 due to plutonium 238. I assumed gross beta activity
7 and that was all due to strontium 90 and assigned
8 that dose.

9 The information that I used was site
10 environmental reports -- same old stuff, employment
11 dates, cancer -- type of cancer and diagnosis dates
12 from Department of Labor.

13 Based on the information that I have there,
14 the annual environmental dose, I normalized that to
15 a 2080 hour work year because she said she didn't
16 work overtime, and had she said she worked overtime,
17 we would have scaled it up. Total dose estimated
18 was 135 millirem over the entire period.

19 Internal dose, assume that the highest gross
20 alpha and gross beta concentrations were inhaled
21 throughout the employment to date of diagnosis, and
22 the total dose estimated was 36 millirem to the red
23 bone marrow. So I took the very highest airborne
24 concentrations, applied those throughout her
25 employment and came up with 36 millirem.

1 The resulting POC here is four percent, so
2 this was, you know, another way of those efficiency
3 measures, and I overestimated the dose every
4 possible way that I could and still ended up with a
5 POC this low. So we were done. This one did take a
6 little bit longer -- 17 hours -- no, it did take a
7 while because I had to run through many, many
8 iterations to make sure that I was choosing the most
9 claimant-friendly solubility class and the most
10 claimant-friendly radionuclide to be applied in this
11 case.

12 Any questions on this one? Okay.

13 **DR. ZIEMER:** Okay, thank you. Let's ask
14 now, are there any further questions on any of the
15 cases that were presented or relating to the dose
16 reconstruction methodologies? Yes, Jim.

17 **DR. MELIUS:** I think these were helpful. I
18 appreciate you taking the time to do it. It
19 probably reflects my ongoing concerns about certain
20 issues, but the one thing that bothered me in terms
21 of what you're presenting is the third case, and as
22 you're presenting it I know you couldn't present all
23 the details and so forth, and I'm not questioning
24 what you did or the way you presented it or your
25 conclusions. But it's just that as you're

1 presenting it I can think of other scenarios that
2 were part of that where you're relying on, you know,
3 a survivor who has very little information, data
4 that's passed through three companies to get to its
5 current storage place, the health safety officer
6 who's not even at the same facility and so forth
7 where facts can get lost and information can get
8 lost in that process. So I think that's probably
9 going to be the biggest challenge to sort of keep
10 track of all this and making sure that the right
11 amount of effort is put in 'cause I don't think it's
12 a question of how much -- I think it is going to
13 come down to a question of how much time and effort
14 do you have to put into particular cases, and my
15 related concern to that is how that information gets
16 recorded so that the next time a case comes in from
17 that same facility -- which happens to be the kidney
18 cancers -- someone doesn't look at that, says
19 there's not much exposure there, I'm not -- you
20 know, we're not going to spend the time on this one,
21 and how you sort of alert people that -- and keep
22 the records as you're processing thousands of cases
23 I think is also going to be a challenge.

24 **DR. NETON:** Yeah, we're very sensitive to
25 that. I mean that is a potential pitfall. I think

1 the ORAU team is going to actually arrange their
2 dose reconstruction teams around facilities, which
3 makes some sense, so they develop a certain
4 expertise on certain areas and AWE's would likely be
5 one of those types of facilities. We do intend to
6 have these databases out there would contain all
7 this information that we obtain to be put in there.

8 **MR. CALHOUN:** And isn't it true now that you
9 can click on that facility and get that data that
10 we've got to use that?

11 **DR. NETON:** Yeah, that facility data that is
12 out there available for the dose reconstructionists,
13 wherever they may be, to evaluate and look at it
14 again.

15 **DR. MELIUS:** So that if there's another case
16 that has additional information or different type of
17 cancer, then it needs to be pursued further and
18 added.

19 **DR. NETON:** In fact if we recover additional
20 information beyond what's here, we would go back and
21 look at that case again as that information becomes
22 available.

23 **DR. ZIEMER:** Jim, in cases such as the one
24 Jim just described, is it not true that to some
25 extent that lack of information and the assumptions

1 you used get also reflected in the uncertainty
2 values that are assigned and --

3 **DR. NETON:** No, on these particular cases
4 where we do these, what we believe the upper
5 bracketing estimates, we do not assign uncertainties
6 because we feel we are already at the upper end of
7 the distribution of the potential doses. We took in
8 every particular instance the highest exposure we
9 could find, so we took the highest worker in that
10 one year and assumed that that highest worker
11 received that exposure every year for 11 years. We
12 had no indication that was --

13 **DR. ZIEMER:** Okay, so that's the equivalent
14 to sampling the same point over and over at the high
15 end. That's like the 99th or 100th point.

16 **DR. NETON:** Exactly.

17 **DR. ZIEMER:** Okay.

18 **DR. NETON:** That makes the job --

19 **DR. ZIEMER:** So it's -- it's actually more
20 lenient than the uncertainty analysis approach.

21 **DR. NETON:** Exactly. If we assign that best
22 estimate, which would be the average worker dose,
23 and put this distribution about it, these -- the PC
24 would have been probably substantially less -- or
25 would have been substantially less.

1 **DR. ZIEMER:** Other questions? Any of the
2 visitors have questions?

3 **MR. SILVER:** Yes, Ken Silver. In the third
4 case, let's say it was seven grams of insoluble
5 uranium, wouldn't the biokinetic models predict some
6 dose to the esophagus due to mucociliary clearance
7 and swallowing?

8 **DR. NETON:** Yes, and that is incorporated in
9 the ICRP-66 lung model itself.

10 **MR. SILVER:** So did I misunderstand? I
11 thought you said that the only dose to the esophagus
12 was through the bloodstream.

13 **DR. NETON:** That's correct. You're right,
14 there are mucociliary transport doses to the
15 esophagus, but even alpha emitter I suspect that
16 that dose would be extremely low. The mucous itself
17 has a blanket that exceeds more than likely the
18 range of the alpha particles.

19 **MR. SILVER:** So that biokinetic pathway was
20 or was not incorporated into this dose
21 reconstruction?

22 **DR. NETON:** It was. The models themselves
23 incorporate all the relevant ICRP information,
24 including -- the 66 lung model includes the
25 mucociliary transport, as well as the distribution

1 from the bloodstream into the individual organs,
2 including the esophagus.

3 **MR. SILVER:** Do you recall the relative
4 contributions of blood versus mucous?

5 **DR. NETON:** No, I do not.

6 **MR. SILVER:** Thank you.

7 **DR. NETON:** I don't have it handy.

8 **DR. ZIEMER:** Any other questions?

9 **DR. NETON:** I will just say one more thing,
10 that that is the advantage of using the current ICRP
11 models. The older models do not even allow one to
12 calculate a dose to the esophagus from the
13 biokinetic distribution in the body. It would have
14 been zero under the old model -- or uncalculable
15 (sic).

16 **DR. ZIEMER:** Thank you. We're already
17 scheduled for a break. We'll take a 15-minute break
18 and then we'll adjourn (sic). Thanks.

19 (Whereupon, a recess was taken.)

20 **RESIDUAL CONTAMINATION STUDY PROGRESS REPORT**

21 **DR. ZIEMER:** All right, we are ready to
22 reconvene. Under the National Defense Authorization
23 Act of 2002, NIOSH has a particular responsibility
24 that we're going to learn more about now, and Grady
25 Calhoun is going to make a presentation about this

1 activity called the residual contamination study.
2 Grady?

3 **MR. CALHOUN:** Okay.

4 **DR. ZIEMER:** And Board members, there is a
5 packet in your -- or a copy of the presentation in
6 your notebooks.

7 **MR. CALHOUN:** All right. As you said,
8 National Defense Authorization Act tasked us to
9 undertake a study to evaluate the potential for
10 residual radioactive and beryllium contamination at
11 Atomic Weapons Employers and beryllium facilities
12 that processed these materials in support of nuclear
13 weapons production.

14 What we're supposed to do is to determine
15 whether or not significant contamination remained
16 after the facility discontinued activities related
17 to weapons production. And if it did, could such
18 contamination -- could it have caused or
19 substantially contributed to cancer or a covered
20 beryllium illness, as -- whatever the case may be.

21 So what we started out with is there was a
22 -- there is a list of AWE's and beryllium facilities
23 on a web site, the DOE Office of Worker Advocacy web
24 site. And along with that is a listed date, a
25 listed period that pretty much establishes the time

1 that people can -- would have had to have worked
2 there to start filing.

3 Now we've learned that this is somewhat of a
4 dynamic site and that these dates change, so we had
5 to go with a snapshot of the information because for
6 a study like this, we couldn't have a moving target
7 because we would never really be done with any
8 individual facility. So we used a snapshot of the
9 facility and that was a snapshot taken I believe
10 February 15th, and we used that throughout the
11 course of the study.

12 We had two tasks, and the first one was to
13 come up with a progress report, and then a final
14 report. And so for the first part what we thought
15 we would do was to look at all the available
16 documentation and try to make a judgment as to the
17 adequacy of the listed periods. And what I'm going
18 to do is I'm going to place each one of these
19 facilities in one of three categories, and I'll
20 explain a little bit about these categories.

21 And the three -- one -- the three
22 recommendations are that the documentation reviewed
23 indicates that there's little potential for
24 significant residual contamination outside of the
25 listed period. For something to get that

1 designation, we had to have had either a documented
2 survey which shows that there was a decontamination
3 of the facility. If it's a facility that lists
4 present as the end period, then there's -- it's
5 still covered. It's still in the covered period, so
6 we didn't worry about that one. If the type of
7 operation performed in the document and was -- had
8 very little potential for residual contamination --
9 for example, there are facilities that may have
10 literally handled two rods, and it was done on two
11 days, you know, during one year, and I'm thinking of
12 a -- I don't remember the name of the facility, but
13 we have this one, and Fernald was the people who
14 commissioned that activity, and there's
15 documentation that they went in and did air sampling
16 and did surveys and took the material back after
17 that one or two-day test. So in a case like that,
18 there was little -- little potential for significant
19 residual contamination during the operation, so
20 there would also be little outside of that period.

21 Same goes with beryllium. We'd have to have
22 some kind of documentation that there was a
23 decontamination for us to say that there's little
24 potential for significant contamination.

25 The next category was documentation reviewed

1 indicates there is a potential for significant
2 residual contamination outside the listed period.
3 There were cases where we actually had surveys that
4 said okay, there's contamination here and it was two
5 or three years after the period that was listed on
6 the OWA web site. There's also some -- and I don't
7 know how many of you people have looked at this web
8 site, but there's a lot of operations where it's
9 listed as AWE for three years, then there may be a
10 six-year gap, and the DOE took over after that six-
11 year gap for remediation. Well, I don't have any
12 indication that there was a clean-up or
13 decontamination anywhere in that gap, therefore in
14 my mind the potential exists for significant
15 radioactive contamination.

16 And then the third category, which most of
17 them fell into, was that the site warrants further
18 investigation. And that was just that there wasn't
19 enough information there that could lead me to
20 believe one or -- one -- number one or number two,
21 and I'll show you a little bit how this played out.

22 With the radioactive contamination, the
23 yellow there is, like I said, additional information
24 required. And I think it's like 55 percent or
25 something roughly like that. And there just was

1 very little to go on in these facilities, so we are
2 going to attack these -- I'm getting a slide ahead
3 of myself or two, but these are what we're going to
4 attack in the next phase of this report. Little
5 potential is in the green, and this is because there
6 -- you know, there's FUSRAP data in many cases gave
7 actual surveys of these facilities and in some cases
8 even maps, which is kind of interesting, so you
9 could actually look at the contamination levels that
10 were present. So FUSRAP studies and if, you know,
11 the current -- it's a -- current facilities, they
12 fell into that one. Significant potential, as I
13 said, was facilities where I definitely had
14 something that indicated there was contamination
15 outside that covered period -- listed period, and
16 only 27 of them fell into that. Now keep in mind
17 this is only the radioactive contamination section
18 of this report.

19 As far as beryllium contamination goes, it's
20 a little bit different. Most of these fell into
21 significant potential, and the reason is is that
22 with beryllium there was very -- we have found from
23 looking through the documents is there's very little
24 documented decontamination. And I think it's just
25 because it's -- you know, with radioactivity, we've

1 had programs in place ever since the Navy and before
2 with doing surveys, documenting, decontaminating.
3 And with -- I'll say the industrial hygiene end of
4 things, the data is just now kind of catching up to
5 that and so it wasn't as well a documented
6 decontamination efforts and surveys, and so if a
7 facility had handled beryllium and there was no
8 documented survey or decontamination, we said that
9 there was significant potential at this point.

10 Little potential, you can see that there was
11 only five of the facilities there, and -- that we
12 felt that you could say there was little potential.
13 And I believe that a couple of those are still
14 listed as current, and that's why. It's little
15 potential outside that listed period, because the
16 period is still current.

17 And eight was additional information was
18 required. And again, what we're going to do for the
19 path forward here is we're going to take another
20 snapshot of the OWA web site and actually we've got
21 the person -- the contractor doing this right now.
22 And they're going to look for date changes. They're
23 going to go through and compare the current dates to
24 the previous dates listed, and their determination,
25 and some of them have changed already -- not as a

1 result of our report, but as a result of their
2 looking into the facilities, have changed to
3 actually match what we have found. So they found
4 the same thing, and not in a lot of cases, but in a
5 few.

6 After we do that we're going to focus on the
7 facilities for which more information was required.
8 We've got a list of contacts gathered. That's
9 corporate contacts or even some health and safety
10 type management contacts. We'll contact them and
11 see if we can get any additional information to try
12 to nail down the time frame when the -- either a
13 clean-up was done or the facility was demolished, in
14 some cases.

15 We're going to look at additional document
16 searches. I believe somebody mentioned EML. That's
17 potentially a good source. The FUSRAP collection is
18 just enormous, so we plan on having a couple of
19 trips down there to do some searches for the
20 facilities that are listed as the yellow ones, and
21 contact with site reps. If we have to we'll do some
22 on-site visits. That may not do a whole lot of
23 good, unless the end point is relatively recent. So
24 that's where we're going with that as far as the
25 final report goes. And that's it for that slide.

1 Yes, sir?

2 **DR. ZIEMER:** Grady, I wanted to ask you
3 about the use of significant. Now you talk about
4 significant potential for contamination and you also
5 talked about significant contamination.

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

7 **DR. ZIEMER:** I'd like to ask about
8 significant contamination.

9 **MR. CALHOUN:** Well, what we're --

10 **DR. ZIEMER:** Do you have a number or a group
11 of numbers or --

12 **MR. CALHOUN:** Well, what we did with
13 radioactivity was we used the current DOE/NRC
14 standards for contamination. If we had some
15 indication that there was uranium 1,000 DPM loose in
16 a facility -- I'm just throwing uranium out 'cause
17 that's one of the ones that we all know -- we
18 considered that significant. For beryllium there's
19 really not a widely accepted number that I'm aware,
20 so if they handled beryllium and there's no
21 decontamination noted or documented, the potential
22 exists until we can come up with a better way -- err
23 on the claimant's side on this one.

24 **DR. ZIEMER:** At some point, though, you need
25 a working number, I presume, for beryllium, and

1 maybe for other nuclides.

2 **MR. CALHOUN:** Well, you know, there's -- we
3 certainly do have those numbers for all the
4 radioactive constituents, you know. You know, for
5 plutonium you need 20 DPM alpha loose, and for the
6 uranium would be 1,000 loose. With the beryllium, I
7 don't know that. And we do have an industrial
8 hygienist working on this report for us and he's a
9 little bit smarter than I am about industrial
10 hygiene beryllium issues.

11 **DR. ZIEMER:** Other questions? Can you give
12 us an idea of how this program meshes with the
13 compensation program and -- to the extent to which
14 it doesn't mesh and impinges on it, in terms of
15 staff --

16 **MR. CALHOUN:** Well, it impinges on it only
17 because it takes our resources to some degree.

18 **DR. ZIEMER:** That's what I was asking.

19 **MR. CALHOUN:** But there will be some benefit
20 gained. From going through these reports, this will
21 help our site profile -- build the site profile of
22 many of these facilities, so the contractor is aware
23 of that and knows that when he finds any good data
24 like that that we need that so that we can organize
25 that in a way that will help us do dose

1 reconstructions later. So you know, ultimately I
2 think it's more of a benefit to us than a hurt
3 because I think it'll give us a lot of good
4 information from the radioactive standpoint, and
5 maybe somebody else can use it from the beryllium
6 standpoint -- physician review panel or whatever.

7 **DR. ZIEMER:** Other questions?

8 **MR. MILLER:** Can I try to answer that
9 question a little bit differently?

10 **DR. ZIEMER:** Sure.

11 **MR. MILLER:** There was a reason Congress put
12 that in the Defense Authorization Act, and it wasn't
13 to impinge on NIOSH's scarce resources. It was put
14 in the Defense Authorization Act because there were
15 clearly identified in a number of regions of the
16 country facilities which, after they terminated
17 their work -- atomic weapons facilities -- that
18 after they had terminated their work they were not
19 either decontaminated or the quality of the
20 decontamination was so poor and that when folks went
21 back to do, for example, the FUSRAP analysis, they
22 found a lot of contamination. There also had been a
23 number of compensation claims based on -- we'll call
24 it the hot facility syndrome that had been denied
25 under state compensation law, and so a number of

1 folks had approached members of Congress to see if
2 it would be -- if it was simply, you know, an
3 isolated circumstance where workers -- for example,
4 at Union Carbide in western New York at the Linde
5 facility, which was one of the facilities of
6 interest, which was very contaminated, even after
7 they stopped doing uranium work for the AEC, was
8 there any potential. Should, therefore, this be
9 studied with an eye towards Congress potentially
10 expanding the coverage dates for eligibility for
11 applying for compensation. So I don't think this
12 was an -- I just wanted to clarify the record that
13 this was not an activity done in a vacuum and that
14 there won't be a follow on response from Congress
15 once NIOSH has done the science.

16 **DR. ZIEMER:** Thank you, Richard, for that
17 clarification.

18 **MR. HALLMARK:** Chair, could I ask a
19 question, as well?

20 **DR. ZIEMER:** Yes.

21 **MR. HALLMARK:** Shelby Hallmark, Labor.
22 Clarifying and following on Richard's comment, you
23 didn't really focus as much on the second part of
24 the question that was -- I thought, Grady, with
25 regard to having found that there is a significant

1 contamination, does it have a cause -- is it
2 potentially a cause of the disease. It seems to me
3 that in answering the question that Congress has
4 posed to you, which is should we expand the periods
5 of time for which individuals can successfully claim
6 covered employment, that NIOSH needs to look at
7 making a determination about is it -- is there
8 really sufficient -- I mean even if a facility has
9 contamination, is it sufficient to make a difference
10 in terms of real dose reconstructions. And for the
11 panel's purposes, I mean just explain that -- as
12 Grady suggested -- the -- finding this information
13 about the tail of contamination is already helpful
14 for dose reconstruction for employees who can
15 establish a covered employment period because if
16 they continued to work at that site, that time would
17 -- and the radiation is measured, that radiation
18 would be added to their current dose reconstruction.
19 But an employee who comes to that site after the
20 period that is the covered period would now
21 currently not be able to file a claim successfully,
22 absent Congressional action based on this report.

23 So my question is, has the study been framed
24 in such a way that you'll be able to sort of answer
25 that question at AWE facility X it looks as if yes,

1 that residual contamination is sufficient that it
2 would -- that it should be looked at for expanding
3 the exposure -- the covered employment period.

4 **MR. CALHOUN:** And with the radioactivity I
5 believe that we did have that in our mind when we
6 were looking at that, because if I've got something
7 that would classify as a contamination area under
8 current regulations, I've got to consider that that
9 does have the potential to result in a cancer.
10 Because as we all know here, there's -- depending on
11 the type of cancer that's out there, I could have
12 airborne radioactivity, and if I'm looking at
13 prostate cancer it's way different than lung cancer.
14 So I think that we're certainly erring on the
15 claimant-friendly side to say that if it exceeds the
16 limits that would currently need controlling under
17 DOE, that it has the potential for significant --
18 for impacting a cancer or beryllium illness.

19 **DR. ZIEMER:** Well, I might comment that I
20 think that's a real stretch. First of all, going
21 from surface contamination limits to body doses is
22 not a trivial exercise, and I don't know how you're
23 going to do that in a very good manner that -- I
24 mean there's some pretty rough models you can use,
25 but that's a tough one. And if you use, for

1 example, the Brodsky* magic number, which is ten to
2 the sixth, which says that if you have -- huh? --
3 ten to the minus sixth -- it depends on which end
4 you're looking at. Six orders of magnitude, in
5 other words.

6 **UNIDENTIFIED:** (Inaudible)

7 **DR. ZIEMER:** No, it's six orders of
8 magnitude that the amount of, for example, uptake
9 you would get from a pretty sizeable surface
10 contamination turns out, in many cases, is virtually
11 trivial. So the stretch of saying that --

12 **MR. CALHOUN:** It is, but what you're
13 thinking of is what we're actually doing, is we're
14 going to end up having to do dose reconstructions.
15 We're not saying -- we're not applying a dose
16 because there's surface contamination. What we're
17 doing is we're opening up a period that we could do
18 a dose reconstruction and based much more on just
19 surface contamination during that period.

20 **DR. ZIEMER:** Sure.

21 **MR. ELLIOTT:** I think the --

22 **DR. ZIEMER:** Larry.

23 **MR. ELLIOTT:** I'm sorry. I think the second
24 part of the question was -- to us -- and could that
25 contamination, that residual contamination, have

1 caused harm. That's the way it was phrased. Right?

2 **MR. CALHOUN:** I'd have to go back --

3 **MR. ELLIOTT:** And so your criteria that
4 you've set is the current regulatory limit.

5 **MR. CALHOUN:** Right. Well -- oh, well.

6 **MR. ELLIOTT:** While Grady's looking for
7 that, just let me --

8 **MR. CALHOUN:** I can find the actual words
9 here 'cause I pulled them right out.

10 **MR. ELLIOTT:** I anticipated this question
11 but it hadn't come up yet -- where is this report
12 at? We're talking about a progress report. It's
13 not on our web site. It's not at the table at the
14 back. It is in the final throes of clearance within
15 the department and we're hoping that it'll be
16 released to the six subcommittees identified in the
17 Act -- or in the amendment language that we need to
18 deliver it to -- this week, I hope. We've been
19 trying to move that through for the last few weeks,
20 but it's very close, I understand. So as soon as it
21 is delivered to the committees on the Hill, it will
22 be placed on our web site and you'll be notified.

23 **MR. CALHOUN:** There's another question
24 behind you.

25 **MR. SCHAEFFER:** Mike Schaeffer, Department

1 of Defense. I have a question. Is the Iowa army
2 ammunition plant considered in your group of
3 facilities studied?

4 **MR. CALHOUN:** I don't know off the top of my
5 head but I can look. I've got the report back there
6 in my -- I think it is. I've got the report under
7 my chair right there.

8 **MR. SCHAEFFER:** My interest -- this is a
9 very unique situation where, although the Army is
10 the one that ran the plant, the AEC actually was
11 there co-operating it, side by side with the Army.

12 **MR. CALHOUN:** Yeah, I'll check. I have
13 that, like I say. I'll get back to you. I'll look.

14 **MR. SCHAEFFER:** Thanks.

15 **DR. NETON:** I think the answer to that
16 question is they're certainly covered under the Act
17 and I think they're listed as a DOE facility, not an
18 AWE.

19 **MR. CALHOUN:** Yeah, we wouldn't have looked
20 at DOE facilities. This study included only AWE's
21 and beryllium facilities. If they were listed as an
22 AWE and a DOE, we included them. If they were
23 listed just as a DOE facility, they weren't included
24 in this study.

25 **DR. ZIEMER:** I'd like to ask another

1 question. Maybe Richard Miller will have to answer
2 this, but I think -- I would be more concerned about
3 what the residual activity indicates about previous
4 work habits than saying I'm going to use those
5 activity levels to reconstruct the dose. Typically,
6 sloppy work habits result in surface contamination.
7 And simply to reconstruct based on the numbers --
8 the contamination levels, seems to me misses the
9 point. The point is if those contamination levels
10 existed, there must have been some pretty sloppy
11 work habits, and what does that mean? Do we know --
12 you know, what's the intent here? Is it simply to
13 quantitate this or to identify where the practices
14 were pretty loose, or who knows the answer to that?

15 **MR. CALHOUN:** I would -- you know, I'm
16 guessing on this one, but like Richard said earlier,
17 the point is to see if those dates that are listed
18 are too restrictive. Were there contamination
19 levels at a point that we need to allow additional
20 people to file? That's my take on it, I --

21 **DR. ZIEMER:** Okay.

22 **MR. MILLER:** I agree with Grady. I mean --

23 **MR. CALHOUN:** Oooh!

24 **MR. MILLER:** Is that a problem? Let me
25 start over. For the record, this report was due to

1 Congress on June 28th of this year and it is now
2 three months late. We would like a clearer answer,
3 Mr. Calhoun. Is that better?

4 **MR. CALHOUN:** Yeah, thanks.

5 **MR. MILLER:** In answering your -- Dr.
6 Ziemer, just to give you an example of a case where
7 -- as a practical applied case. We have a green
8 salt storage facility in which an individual was
9 charged with going into and remove the concrete that
10 was contaminated that had sat with green salt in it
11 for many years. The -- and black oxide. And so the
12 question was, that individual who did that job was
13 breathing in cold war material in a facility that
14 went on to actually produce chemicals. Question:
15 Should that individual have the ability, if they
16 were working in a, quote, hot facility and they got
17 lung cancer and they want to file a claim under this
18 program to be able to be -- able to apply and see if
19 it would be possible to do a dose reconstruction to
20 determine whether they would be compensable. And so
21 it's to deal with those types of remedial cases, I
22 think, that were motivating people and not did you
23 work at a facility because there were some
24 unremovable, you know, fixed contamination that
25 you're somehow automatically eligibly -- eligible or

1 compensable, and I don't know that that's where
2 anyone's heading on this.

3 **DR. ZIEMER:** Any other questions? Okay.
4 Oh, here's one. Sally.

5 **MS. GADOLA:** I just had a comment. There
6 has been stories in literature, in *Occupational*
7 *Health* about accidental spills -- this gets to your
8 sloppy work habits -- and some of those were related
9 to beryllium that showed up on secretaries pages, on
10 reports. Also radioactive contamination on
11 materials that should not have been contaminated.
12 And those are really hard to track down, and we do
13 hear about those stories every so often. And I was
14 wondering if any of that is a part of your
15 investigation?

16 **MR. CALHOUN:** I would say not those
17 individual kinds of cases, but I would imagine that
18 in the instance where let's say that the beryllium
19 contamination ended up on the page of a secretary's
20 desk or something, I think that we would have some
21 indication that that facility handled beryllium
22 during that period and therefore that would be a
23 covered period, unless there was a documented
24 decontamination. As you saw with the beryllium in
25 particular, there's very few documented

1 decontaminations at beryllium facilities that we've
2 been able to put our hands on. And the same thing
3 with the radioactive material. If -- I guess there
4 is a slight chance that something like that would
5 happen after a decontamination, but I don't think
6 it's as -- I don't think it's that likely.

7 **MS. GADOLA:** Thank you.

8 **DR. ZIEMER:** One question on -- are you
9 looking both at fixed and loose --

10 **MR. CALHOUN:** Yes.

11 **DR. ZIEMER:** -- contamination?

12 **MR. CALHOUN:** Yes.

13 **DR. ZIEMER:** Is there an analogous situation
14 for beryllium? I simply don't know. Is there --
15 are there cases where facilities may have tried to
16 fix beryllium by coating or something, where it
17 might later --

18 **MR. CALHOUN:** I'm going to answer that --

19 **DR. ZIEMER:** -- and if so is there a test
20 for surface beryllium?

21 **MR. CALHOUN:** Is there anybody --

22 **DR. ZIEMER:** But that's for loose --

23 **MR. CALHOUN:** Right, so I would -- you know,
24 I don't know that if in the industrial hygiene
25 world --

1 DR. ZIEMER: I would think there might --

2 MR. CALHOUN: -- a fixative --

3 DR. ZIEMER: -- be an X-ray fluorescence --

4 MR. CALHOUN: -- applying a fixative --

5 DR. ZIEMER: -- process --

6 MR. CALHOUN: -- would be okay.

7 DR. ZIEMER: -- that somebody could use

8 in --

9 MR. ELLIOTT: Well, I think they can do
10 that. They can use X-ray fluorescence to pick it
11 up, and they can use white tests, but I don't
12 believe that -- in my experience at NIOSH with
13 industrial hygiene and I don't believe there's any
14 process that I know of where they've fixed it in
15 place. They've tried to remove it. They do their
16 best to remove it and recover it, take it away, but
17 not fix it in place like we see with radiation.

18 DR. ZIEMER: Okay, no further questions on
19 this topic? Yes, Robert? No? Thank you. Let's
20 move on then.

21 **DEPARTMENT OF LABOR ACTIVITIES UPDATE**

22 Next we're going to have an update on the
23 Department of Labor activities and that presentation
24 will be given by Shelly (sic) Hallmark. Shelly's
25 the director of the Office of Workers Compensation

1 Programs at the Department of Labor. Shelly?

2 MR. ELLIOTT: Shelby.

3 DR. ZIEMER: Shelly, Shelby.

4 MR. HALLMARK: I'm going to try to follow
5 this on two different machines here, so Grady, this
6 will take 36 hours.

7 MR. CALHOUN: We'll report that to Jim.

8 MR. HALLMARK: I'm a graduate of the
9 University of Texas so I really would like to do
10 this presentation under the longhorns over here. If
11 longhorns were really that big we'd have won on
12 Saturday, obviously, but no such luck.

13 I just wanted to start out this morning --
14 this afternoon -- you left me till last here. This
15 is not fair, so I assume that energies may be
16 flagging. And if they are, I will attempt to be
17 silly from time to time. Don't consider that we
18 don't take this business seriously, but it is late
19 in the afternoon here.

20 I want to start off, however, by -- I want
21 to start by saying that we are proud of what the
22 Department of Labor's been able to do so far. It's
23 not a perfect program, as you'll see from my slides,
24 but we do think we've gotten a good start. But I
25 also wanted to really give my thanks and admiration

1 to the NIOSH folks that are here with you. They
2 have really, in our view from the Department of
3 Labor, shouldered the task of getting this program
4 up and running. As some of you, Richard, may
5 remember, as this program was discussed early on,
6 before it was actually enacted, HHS was a little
7 leery, to say the least, about what its role was
8 going to be and what it should be. But all of that
9 history aside, when NIOSH got the call to do this
10 work in the Executive Order, they have taken it on.
11 And from everything we've been able to see and in
12 our cooperative interactions, are doing a tremendous
13 job. And obviously your job is to validate that,
14 and I'm sure you'll do that, but I certainly would
15 say that from our perspective over at Labor, this
16 has been a really good effort, even though it takes
17 some of the employees a long time to do their dose
18 reconstructions.

19 Just a few highlights -- these are in your
20 book so I'm not going to dwell on them. We are
21 proud of the fact that we got started on time and
22 that we've gotten checks rolling, and we've absorbed
23 the amendments that took place this past December
24 and made the changes to the way that that process
25 works.

1 And I can't do this, forget about it. I'll
2 just have to use one at a time. I had some
3 brilliant notes that are in here, but I can't find
4 them, so I'll just go through and see if they come
5 to me as we go through these slides.

6 We're doing a bunch of things to try to
7 expedite the process of getting claims pushed
8 through our system, as much as we can. We are
9 working with getting employment information from
10 DOE, especially on subcontractors. That's turned
11 out to be a really hard piece. We're working with
12 the Center to Protect Workers Rights on getting
13 employment information on construction workers.
14 We've gotten on-line access from ORISE so we can
15 bypass the record centers in DOE to get straight to
16 the data that they have on 400,000 plus employees.
17 We've worked with the National Cancer Institute on
18 defining what a cancer is and where those boundary
19 lines are with respect to the -- especially the SEC
20 cancer, the cancers that are on that list. And
21 we're working on our Department of Labor rule.

22 As you may recall, we published an interim
23 final rule back in May of 2001. That's what we've
24 been using to actually implement the program. We
25 expect to publish -- we hope to publish the final

1 rule fairly shortly, taking into account the
2 comments that have been received.

3 We are in the Department of Labor moving
4 ahead with the staffing and we have what I consider
5 to be a fully functional operation now. We've got
6 about 200 total staff -- Federal, that is -- and
7 about 50 contractors who support us. We are adding
8 staff as we need it, and we may need to add
9 considerably more as time goes on, but we think we
10 have an adequate group now.

11 One of the things that we're doing right
12 now, and this is relevant, especially to folks from
13 New Mexico who are in the room, is we are trying to
14 balance out our workload. The work -- we expected
15 the workload to be organized differently than it is.
16 Hanford and our Seattle office have not produced
17 nearly as many claims as we expected. Denver got
18 more than we expected. And as a result, even though
19 we've tried to balance staffing, we have an
20 imbalance in Denver and the claims processing has
21 not been as speedy as we would like to see it. So
22 right now we are working with Congressional
23 representatives to look at moving some of the cases
24 out of our Denver area and into Seattle's because
25 that will balance out the workload. We think that

1 -- Iowa and Missouri are the two states that we're
2 thinking of moving, if that will take, we hope, only
3 a week or two for us to finalize and get moving.
4 And we'll obviously communicate with the claimants
5 who are affected, but it'll -- it should speed
6 processing throughout the Denver region.

7 This is how our regions are split up
8 currently. And as you see, the two peach-colored
9 states in the middle there are the ones that we're
10 going to pull out of the Denver blue and move over
11 to the Seattle electric yellow. The other two
12 offices are Cleveland and Jacksonville.

13 We've gotten this many claims -- this is in
14 your books or the handouts, if you don't have it, so
15 you can run through this. This is as of about a
16 week ago, so these data don't necessarily track with
17 some that you may have seen earlier from our friends
18 in NIOSH, but it's usually just a timing issue. But
19 there's also -- these data are also captured on our
20 web site and we update data weekly. These are
21 claims, the 34,700 is claims. When that's reduced
22 to claims; i.e., individual workers, I think it's
23 down to about 27,000, so you see you can have
24 multiple claims for one case.

25 And this tells you something about the

1 population, the yellow being survivor claims versus
2 living employee claims. That's an indicator of the
3 difficulty that NIOSH will have because we do have a
4 largely survivor population, so that makes dose
5 reconstruction more difficult.

6 I put these two slides in just to give some
7 information about one thing that I wanted to
8 particularly emphasize in my talk today, and that is
9 that we have a lot of claims coming in for the part
10 B part of EEOICPA, which is what the Department of
11 Labor administers, which are really part D claims.
12 That is, they are not for radiation-induced cancer,
13 beryllium disease or silicosis for miners. They are
14 all these other things, and that's what this -- you
15 don't need to study this in any great detail, but
16 this is all claims which are for conditions which
17 are not covered under our part.

18 Unfortunately a lot of claims have come in
19 because people were not clear on which aspect of
20 this program to use. The DOE program has not been
21 -- up until recently wasn't up and running and
22 therefore I think a lot of people filed a claim
23 somewhere, but that has in fact slowed us down
24 because all we can do with claims for these kinds of
25 conditions is go through all the process and give

1 the individual a denial and point them to the DOE
2 program, and that's what we've been doing. But
3 hopefully the information will go out that will show
4 -- that will advise people to go to the right place
5 in the first place.

6 This is just the same information, with the
7 most common circumstances. I think the next to the
8 last one, 18 percent, is other, and that consists of
9 a bunch of odds and ends which, again, are not at
10 all covered by the program. Some of which are not
11 covered by the DOE program, either. Hearing loss,
12 for example; occupational disease cases that are not
13 toxic conditions.

14 This gives you -- and this again is in your
15 data -- your packet so I don't need to go through it
16 all, but this gives you an idea of what we
17 accomplished. We have a two-stage decision process.
18 There's a recommended decision in the district
19 offices, and then a final decision from our final
20 adjudication branch. And as you can see there,
21 about 9,000 cases have gone all the way through to
22 final decision. But of course a big chunk of cases,
23 this 8,400 as of last week sometime, have gone over
24 to NIOSH and they can't go to either recommended or
25 final decision until the dose reconstruction is

1 completed.

2 One thing that I would point your attention
3 to is that although we've spent -- we've paid out
4 about \$350 million so far, the medical benefit
5 payment so far is very low, and that's a piece of
6 information we would like people to get out to the
7 public who are affected. People should be filing
8 their medical bills with us so they can be paid by
9 the Department of Labor and not by whoever their
10 health carrier is or Medicare. It should come out
11 of this program. It would be to the benefit of the
12 injured worker and ultimately to the benefit of the
13 overall working of this program.

14 Final decisions have been mostly the green
15 kind that we paid cash for. The ratio of green to
16 yellow is going to change as dose reconstruction
17 occurs because I think everyone understands that
18 dose reconstruction is going to be a process that
19 finds some large percent of people do not in fact
20 meet the test, but this -- but we haven't gotten
21 there yet and so this doesn't really contain any
22 significant number of dose reconstruction cases.

23 This is a very interesting slide, again
24 going back to the comment I was making earlier about
25 other conditions. You see the approvals over there,

1 5,400 approval cases. The breakout of the final
2 decisions that were denied shows that by far the
3 largest percent is that aqua bar, and that is the
4 other conditions that shouldn't have come to us in
5 the first place. So when you look at the ones that
6 we've actually denied because it wasn't an employee
7 or the survivor's not an eligible survivor or they
8 couldn't prove the case -- they claimed one of the
9 correct conditions but they couldn't prove it, the
10 red -- or the -- I think it's red bar, those are
11 fairly small compared to that big aqua bar which
12 says -- which is for the wrong kind of condition
13 altogether.

14 This is -- we have a goal in the program to
15 get our processing done within -- at the district
16 office level, this is the initial cut. We want to
17 get everything done within the first 180 days for
18 AWE and beryllium vendors, or within 120 days for
19 DOE facilities and RECA claims, RECA being the DOJ
20 program that we had a supplement to. We thought
21 that 120 days was plenty for those places like Oak
22 Ridge and Hanford where the data should be
23 relatively available. As I mentioned earlier, we've
24 run into a lot of problems that we didn't expect,
25 one of them being that there's so many subcontractor

1 employees. That data's not readily available. So
2 as it turns out, this is not going to be an easy
3 task.

4 Our actual performance during the past
5 quarter that just ended in September was it took us
6 about 216 days to complete an AWE and beryllium case
7 and it took about 171 days for a DOE case, so
8 neither one of those are meeting the standard, and
9 that sounds like an indictment of the program.
10 Actually that number went up this past quarter and
11 the reason for that is that we're working hard to
12 get rid of the backlog of cases, and that actually
13 causes the average to go down because you're
14 cleaning out the old dogs that have been sitting
15 around. But that number will go down with time. We
16 are moving -- we're going to move to get that
17 backlog of cases that we have resolved so that we're
18 down to just what is current, and that would be --
19 probably a current inventory for us would be about
20 5,000 or less cases. We have about 8,400 cases now
21 in inventory, so we've got about 3,000 that we need
22 to squeeze out of that system and we expect to do
23 that in the next two or three months, especially
24 with things like moving the cases from Missouri and
25 Iowa. And so at that point we'll be able to move

1 cases I think through in 2003 on -- in terms of our
2 goal, meeting our goal.

3 And this just gives you an overall picture,
4 and the red cases are ones that are in process and
5 our district office hasn't reached it's initial
6 point on. And those are the ones I would say we
7 need to get down to about -- we need that to be down
8 to about 5,000 instead of 8,400. And when we get to
9 that, we'll be very current.

10 And again this is cases, 27,000 cases versus
11 34,000, 35,000 claims.

12 Just some information for you with regard to
13 the DOE work sites that are here in New Mexico. As
14 you can see here, we've received about 1,400 claims.
15 Final decisions, only 125. That's relatively anemic
16 compared to the overall graph that I was at on the
17 previous page, but that's because almost all of
18 those cases have to go through the NIOSH process.
19 And so because that's the case, because there's no
20 Special Exposure Cohort here, we haven't reached
21 nearly as many final decisions. And the ten cases
22 that are paid are probably all beryllium cases,
23 would be my guess.

24 And this tells you a little something about
25 the types of cases, overwhelmingly cancer. But if

1 you notice again, other, the non-eligible cases, for
2 our part, 578, a very large number of those cases
3 which will be -- unless we go back in our -- in the
4 process of developing the case and discover that
5 there was a covered illness, those cases will end up
6 being denied and it's slowing down the process for
7 everyone else.

8 That's the same graph for New Mexico that I
9 showed for the country as a whole. And as you see,
10 the red bar is higher vis a vis the total claims
11 received, and that's bad. That's why we're moving
12 cases from Denver to Seattle. Seattle has almost no
13 red bar, and this will even that out and it will
14 allow Denver to catch up and Seattle will take care
15 of those other cases and we'll be -- I think
16 everyone will be better off.

17 This is just the same data for Los Alamos,
18 specifically. Again, this does not include --
19 neither of those slides includes RECA cases. And
20 here's RECA. This is primarily uranium miners out
21 in the northwest corner of New Mexico, and as you
22 see there we have a number of final decisions in
23 RECA because that process is very, very rapid and is
24 completely within our control once we get the
25 information from the Department of Justice. So you

1 see there a lot of cases have been paid in New
2 Mexico under the RECA program.

3 And I think that's it. And I hope I have
4 kept you awake long enough to get through all of
5 this and be glad to answer any questions.

6 **DR. ZIEMER:** Let me start off the
7 questioning and ask about your staffing. We've been
8 concerned about NIOSH's staffing and ability to
9 handle the workloads. Give us an assessment of your
10 Federal and contracting staffing for this effort.
11 Are you where you want to be or...

12 **MR. HALLMARK:** As I said, I think we're
13 pretty close to where we want to be. We have some
14 additional hiring that we're doing right now will
15 probably take us up another ten percent or so. We
16 have authorization to hire more, but it's my -- as I
17 explained, I believe we're going to be current with
18 our workload in the next two to three months. We
19 have that initial hump of cases that we got. I
20 think we're going to have those cleared out, and we
21 don't want to bring on a bunch of additional staff
22 that would -- with our workload actually trending
23 down right now, would not -- you know, we'd end up
24 not having an efficient operation. We're receiving
25 roughly 250 new claims per week right now in the

1 part B program, and that's been gradually declining.
2 It was up 500 or more per week earlier.

3 Now we expect -- you know, I frankly
4 acknowledge that when the NIOSH process begins to
5 roll cases back to us in volume -- we've gotten only
6 nine cases back so far, so that's only a -- you
7 know, just a test group, really.

8 But when the volume of cases start coming
9 back, it may very well be that individuals out there
10 in the sites will reconsider their situation and
11 we'll receive more claims. That's something we'll
12 obviously look at, and we're in a position now where
13 we have a well-framed operation. We have training
14 materials available. We can bring new people on and
15 bring them up to speed very rapidly, as needed. And
16 that's what we'll do obviously if the workload
17 arises.

18 **DR. ZIEMER:** Any questions?

19 **DR. MELIUS:** Yeah. This issue with the
20 other disease cases that are inappropriate for DOL,
21 how are you handling -- I mean do you think it's
22 just people don't know where to go or is there some
23 outreach efforts or informational efforts, or do you
24 think that DOE -- developing a process and will take
25 care of that by itself?

1 **MR. HALLMARK:** I think it's probably all of
2 the above. I mean I -- clearly I think we got a lot
3 of claims in the early going because the program was
4 announced. There was not a lot of information and
5 DOE's part of the program was not in place. Their
6 final reg wasn't actually published until I guess a
7 month or so ago. And so I think some people just
8 came to us because we were the only game in town.
9 There may have been outreach efforts to sort of drum
10 up support, I don't know. But we've tried to get
11 the word out about where you should go. And now
12 that there is a DOE program, I'm hopeful that we
13 will sort that out and people will be headed in the
14 direction that they need to be headed and we won't
15 waste people's time. But as I said, when we get
16 those kinds of claims, we do provide -- we worked
17 with DOE and we do provide in the -- when the
18 decision goes out saying we're sorry, you're not
19 eligible under this program, we do provide them with
20 information about where to go to file the part D
21 plan.

22 **DR. MELIUS:** Secondly, on the medical claims
23 issue, that number surprised me also because one of
24 the things -- I mean your office has been using and
25 certainly we've been using in terms of getting --

1 reaching out to members is one of the benefits of
2 filing a claim is to get your medical care covered,
3 and it's obviously a big issue for many people, yet
4 people don't seem to be following up, and is that
5 true in your -- some of your other compensation
6 programs you handle or is it something unique to
7 this program because of the -- some of the time
8 frames involved, survivors applying, things like
9 that?

10 **MR. HALLMARK:** Well, obviously survivors are
11 not eligible so that's off the table.

12 **DR. MELIUS:** Yeah.

13 **MR. HALLMARK:** And in -- I think it's unique
14 to this program in that a lot of the population here
15 has coverage under a health package from their
16 employment. I think people don't -- and there's a
17 concern, and we've done some outreach on this.
18 There's a concern that physicians are uncomfortable
19 with filing with us and that they will have to fill
20 out voluminous workers comp type reports and so on,
21 which is not the case. I mean we take exactly the
22 same form that Medicare and everybody else takes,
23 and it's just a matter of getting it routed to the
24 right place. But we need to do that outreach to
25 make sure that people get it. But people do need to

1 know that they're paying out of pocket and co-pays
2 and co-insurance now for these services that would
3 be paid 100 percent, first dollar, by us. That's
4 what the program is supposed to deliver, and it will
5 be to everybody's advantage to get that started as
6 early as possible, and we would like that
7 information out.

8 **DR. MELIUS:** I mean I thought your process
9 was very claimant-friendly when I heard it explained
10 and so forth. I was impressed.

11 I'd also like to say I think -- you know,
12 I've been very impressed with the good job that your
13 agency's been doing on this program, 'cause I
14 remember you were a little bit reluctant to take
15 this on a long time ago.

16 **MR. HALLMARK:** There was reluctance all
17 around the table, you know, at a certain point. No,
18 that's right. One of the things that's been very
19 positive about this is that we do have the
20 sufficient support from Congress and funding to do
21 the job the right way, and I'm sure that as the
22 program changes and there are fluctuations and
23 there's need for adjustments in the budgets, that
24 that can be done. And we've been very pleased with
25 that. We think we're providing the service that was

1 supposed to be provided in this program. And as I
2 say, I think NIOSH has done the same with what is
3 really the harder part of this whole operation. I
4 would not want to trade places with Larry as far as
5 the two pieces of work that have to be done.

6 **DR. MELIUS:** Of the three agencies, you're
7 the only one without the advisory committee, though,
8 so it may explain --

9 **MR. HALLMARK:** That explains how quickly we
10 begin to operate.

11 **DR. ZIEMER:** That's why your work is so
12 easy, I know.

13 Roy DeHart has a comment.

14 **DR. DEHART:** While I have you here, a couple
15 of questions that affect the way I deal with some
16 patients. It's my understanding, and I just need
17 your confirmation, that not only is it first dollar
18 pay, it's first dollar on medication, which Medicaid
19 does not cover.

20 **MR. HALLMARK:** Absolutely. We cover any
21 prescriptions, the whole gamut of services, hospital
22 right on through.

23 **DR. DEHART:** And that's what I've advised
24 some patients about. The next concern that they
25 have, do they have to trade physicians, or is any

1 physician eligible to participate as a recipient for
2 their billing?

3 **MR. HALLMARK:** Folks need to get us the
4 information. One of the things that we do when we
5 approve a case is we try to have a personal
6 conversation and identify who the providers are so
7 that we can register them. And those providers are
8 then put in our database and then that's who the
9 individual -- they would continue to use their
10 treating physician and that's -- that's the whole
11 outreach problem that we have. We do have some
12 individuals where we just don't know who their
13 treating physicians are, but that's part of what
14 we're --

15 **DR. DEHART:** Those are the two major
16 concerns that I've repeatedly heard about that
17 because patients don't know that, apparently, very
18 well. And that needs to really be amplified, that
19 you are not changing physicians and your
20 medication's covered.

21 **MR. HALLMARK:** Now there is one complicated
22 area that probably is depressing bill submission and
23 that has to do with the beryllium program, the
24 monitoring program that DOE has run through ORISE.
25 And I think there has -- we are working with DOE to

1 create a -- to move that process over because we
2 actually -- those services ought to be being
3 delivered by the Department of Labor now. On the
4 other hand, when we make -- when we handle medical
5 payments in that context, we do it differently than
6 DOE and ORISE have done in their former worker
7 program. So we're trying to work with DOE to make a
8 seamless transition to make that process work, and
9 that has -- we haven't quite nailed that down. But
10 that's only with respect to the group of people who
11 are beryllium sensitive and being monitored by the
12 DOE program.

13 With respect to anyone who is accepted for
14 any other condition or for beryllium sensitivity,
15 for that matter, if they're not in the ORISE
16 program, we want to get started. We want to get
17 them registered. We want to give them our medical
18 card and get them in the process as quickly as
19 possible.

20 Where's Richard? I figured he'd want to
21 give me some kind of help. Oh, this Richard.

22 **MR. ESPINOSA:** There's quite a bit higher
23 survivor claims. About what percentage of survivor
24 claims get forwarded to NIOSH?

25 **MR. HALLMARK:** I don't have it broken out

1 for that particular categorization. I don't know
2 that there's a reason to believe that the cases that
3 are going to NIOSH would differ from that percentage
4 that I've shown here. But don't forget, the
5 percentage that was shown here was for both DOE
6 employee claims and RECA claims, and so that could
7 affect -- obviously only DOE cases are going to
8 NIOSH.

9 **DR. NETON:** I think I can address that.

10 **DR. ZIEMER:** Jim?

11 **DR. NETON:** The last time we looked at it,
12 about 50 percent of our claimants were survivors.

13 **MR. HALLMARK:** So it's half and half. So
14 RECA --

15 **DR. NETON:** It's fairly consistent with what
16 you've seen.

17 **MR. HALLMARK:** RECA has a very high survivor
18 population because a lot of these individuals who
19 were exposed a long, long time ago.

20 **DR. ZIEMER:** No further comments?

21 **MR. SILVER:** A member of the public, Ken
22 Silver.

23 **DR. ZIEMER:** Ken.

24 **MR. SILVER:** A question about beryllium
25 sensitivity and ORISE.

1 rejection letter to people with non-covered
2 conditions, is there a sentence or paragraph in
3 there about the subtitle D program?

4 **MR. HALLMARK:** There was -- we worked with
5 DOE. Some of the early letters may have gone out
6 without that, but -- my goodness, several -- at
7 least six or eight or ten months ago we started
8 including -- or at least supposedly -- there should
9 be included in each such letter a paragraph that
10 points the individual to the DOE program.

11 **MR. SILVER:** I want to commend you if you're
12 really doing that.

13 **MR. HALLMARK:** We're trying to do that.
14 That's the policy.

15 **MR. SILVER:** Folks in northern New Mexico --
16 I'm relatively new here, but you learn pretty quick
17 that the interactions with the Federal government
18 over the centuries haven't always been good. And
19 you know, be careful what you advocate for or you
20 just might get it. Those of us who got active when
21 this was a twinkle in Senator Bingaman's eye and a
22 lot of other people have tried to follow through and
23 make sure the interaction with the Federal agencies
24 is not too hurtful to folks. In that vein, would
25 you be friendly to an increase in your

1 appropriations for hiring more people to break that
2 backlog of cases?

3 **MR. HALLMARK:** As I said earlier, we have
4 authority right now to hire more people. I don't
5 think we need it at this point. I think we have the
6 capacity to do what needs to be done with the
7 resources that are in place. If that turns out to
8 be not correct, we can remedy that and take care of
9 the additional workload. As I said, Denver was a
10 special case. We had -- because of the large number
11 of RECA cases, we did get a -- behind. And as I
12 say, I would want to say to the folks in New Mexico
13 that the screens, the slides that I showed of the
14 workload and the backlog here, were not, as far as
15 I'm concerned, acceptable. And that's the reason
16 why we're taking action to move cases. I think,
17 though, that once we do that, the Denver office --
18 which is, by the way, just reorganized itself
19 internally a couple of weeks ago -- will be able to
20 take care of the backlog and move on and keep cases
21 current. We'll be meeting the timeliness goals that
22 I showed in Denver as well as the other sites this
23 -- in this year.

24 **DR. ZIEMER:** Any further questions?

25 (No responses)

1 date are not being recorded. We're working with our
2 contractor about doing recordings for quality
3 purposes, and that's not in place yet. But the
4 process that is in place has a designed ability for
5 you to comment back to the interviewer and say you
6 missed this or you didn't account for what we talked
7 about here and I would like to see that incorporated
8 into this interview. And so that's why you get a
9 copy of it, and it's not a final. It's a draft and
10 we ask for your input and your corrections, your
11 edits.

12 **MR. GARCIA:** So I can send it back and --

13 **MR. ELLIOTT:** You can send it back. That
14 should have been made clear. I'm sorry, it must not
15 have been made clear.

16 **MR. GARCIA:** Yeah, it wasn't.

17 **MR. ELLIOTT:** You should send that back.
18 You can -- we'll call you back and talk to you about
19 those and make sure that they are all accounted for
20 in the interview.

21 **MR. GARCIA:** All right.

22 **MR. ELLIOTT:** The recorded interview -- the
23 documented interview.

24 **MR. GARCIA:** 'Cause I didn't give them a
25 phone numbers 'cause I didn't have them, you know,

1 of people that could verify what, you know, we did
2 over there and what spills we had and stuff like
3 that. So can I still send them that, too?

4 **MR. ELLIOTT:** Yes, you can still add to the
5 record at this point, sure.

6 **MR. GARCIA:** All right. Thank you.

7 **MR. ELLIOTT:** Uh-huh.

8 **DR. ZIEMER:** Next is -- if I can read the
9 writing, I believe it's Ben Ortez. Is that correct?
10 Ortiz, I believe it's Ben Ortiz. Okay.

11 **MR. ORTIZ:** Yes, my name is Ben Ortiz and I
12 worked at LANL since '69 till about '89 and I have
13 an occupational illness I acquired at work. Okay?
14 I was exposed to many toxic substances for 20 years
15 and without any safety equipment or anything like
16 that. The way you see me today is the way I worked.
17 Okay? I took my clothing home. It was done -- the
18 laundry, with the one from my family and everything.
19 Okay?

20 While going to the doctors at LANL, you
21 know, I was treated for these symptoms that I had,
22 and they said most of my symptoms were imaginary.
23 Okay? And other things that you said, but
24 nevertheless, they treated the symptoms, like
25 respiratory -- upper respiratory symptoms. So I

1 also went to many private doctors with the same
2 condition. It was very chronic. Okay? I couldn't
3 understand why I would get so sick. I was always a
4 healthy person, always very active in many things.
5 Okay? Sports and stuff like that. I could not
6 understand why, when I would go home with a severe
7 sinus infection or bronchial asthma or flu-type
8 symptoms -- okay? -- and I'd stay home like three
9 days, four days, I would improve. Okay? When I
10 went back to work, again, the thing was just
11 repeated, repeated over and over. And I continued
12 to go to doctors and no one ever asked me what type
13 of work I was doing, what I was working with or
14 anything like that. I had no knowledge myself. I
15 could not understand that these materials that I
16 worked with were actually making me sick. I didn't
17 know that.

18 And actually in the later years, as I
19 progressed on, you know, with different jobs and so
20 forth, my symptoms increased to where I was dizzy, I
21 was nauseated. I developed a chronic insomnia like
22 in the early eighties which one of the lab doctors
23 said the reason I had the insomnia -- his diagnosis
24 was that I was too old. Does anyone agree with
25 that? Are there any doctors here today that perhaps

1 can answer, that a chronic insomnia can come from
2 old age? I was like 49, I believe. Today the
3 insomnia continues with me.

4 **DR. ZIEMER:** Well, I can interject that 49
5 is not old age. That's the only thing I can --

6 **MR. ORTIZ:** And he was the head -- he was
7 the head -- he was the head of the occupational
8 medicine up at Los Alamos. Okay?

9 As I went on, you know, I began to get
10 sicker and sicker. Okay? Until finally I had to
11 leave. They placed me on medical leave back in 1988
12 and one of the doctors that -- when I went for a
13 work history -- it was done at the University of New
14 Mexico -- they sent me to San Francisco to see a Dr.
15 James Cone*, who's a leading doctor at the San
16 Francisco General Hospital, I believe. And he
17 diagnosed me with solvent encephalopathy. Okay?
18 And restricted airways. And then I was sent to
19 another doctor at Berkeley, like in a couple of days
20 after I saw Dr. James Cone. That one -- doctor,
21 after the exam and the whatever, you know, said I
22 was intoxicated, and I didn't like the word
23 intoxicated. I thought he meant that I was
24 intoxicated, but he said no, industrial
25 intoxication. And I'm asking you people here today,

1 who would like to work eight, 12 hours a day
2 intoxicated the way I was? Would any people like to
3 work under those conditions?

4 Anyway, it was 24 hours with me 'cause it
5 never would get away from me. But finally when I
6 was placed on medical leave by the doctors --
7 doctors, management -- it took me seven months for
8 the intoxication to get out of my system, but the
9 damage is there. Okay? The liver, the kidneys, my
10 eyes, you know. The damage is done. Okay? Where I
11 continue to feel lousy.

12 So I think a lot of people like me with a
13 toxic substances illness -- okay? -- I believe that
14 we should also be recognized like the special cohort
15 like they did in Paducah or the gaseous people and
16 so on and so on. We had no idea what we worked
17 with. Okay? No one told us. No safety meetings at
18 all. I was there 20 years. I never had a safety
19 meeting on the hazards of chemicals. No safety
20 clothing or anything like that.

21 Another question I have is someone mentioned
22 about medical expenses. My expense is like \$100 a
23 month that I have to pay out of my pocket. Even my
24 insurance will not pay for it, so how do I do it, to
25 get reimbursed? Who's going to assist me on that?

1 Someone from the Texas Longhorns talking about it?

2 **MR. HALLMARK:** It sounds like you have a
3 proper claim to take to the Department of Energy's
4 worker assistance --

5 **MR. ORTIZ:** Okay, you mentioned doctors. I
6 don't go to a medical doctor. I go to a natural
7 path doctor. Is that covered?

8 **MR. HALLMARK:** Well, that -- the part of the
9 program I'm talking about is run by the Department
10 of Energy and put your -- would put your claim
11 through a physician panel to determine whether it's
12 -- whether your condition is work-related. If so,
13 then your -- then the case would be -- you'd be
14 given assistance in going to I suppose the New
15 Mexico workers compensation program and an attempt
16 would be made to get you benefits through that
17 program. I can't speak to what the rules are in
18 terms of New Mexico, the state system, but that
19 would be how (inaudible).

20 **MR. ORTIZ:** The routing I would take. Okay.
21 I guess -- what does safer healthier people mean
22 through CDC, what does that mean?

23 **DR. ZIEMER:** Where are you reading from?

24 **MR. ORTIZ:** From there (indicating).

25 **DR. ZIEMER:** Oh, CDC, okay.

1 **MR. ORTIZ:** Yeah, CDC. What does that mean?

2 **MR. ELLIOTT:** That's part of the CDC on a
3 logo that they're trying to achieve in their mission
4 vision statements, so that's why it's on that cover.

5 **MR. ORTIZ:** Okay, I was thinking it might
6 date it back to the -- when LANL began. Okay, what
7 happened way back then to safety and health? Who
8 was supposed to oversee LANL's safety and health
9 programs? Apparently not you. OSHA, I think.

10 **MR. ELLIOTT:** No, that would have been the
11 Department of Energy.

12 **MR. ORTIZ:** Well, what happened that -- they
13 were not wise.

14 **DR. ZIEMER:** Certainly the early days it was
15 the U.S. Atomic Energy Commission and the agency now
16 that carries on that mission is the Department of
17 Energy. And I'm not sure -- you've raised some
18 questions here that I'm not sure this -- this panel
19 can answer, but certainly there are some people in
20 the room and perhaps the rep from the Department of
21 Labor can get you on the track here. It might
22 appear that some of the medical conditions you
23 describe which you suggest might be related to
24 chemical exposures, and of course we're well-focused
25 here on the radiological issues, and you may have

1 had some radiation exposures, as well. But it
2 sounds like maybe the chemical issues -- but perhaps
3 there is -- are folks here that can help on an
4 individual basis, where the panel may not be able to
5 directly deal with your case but there are folks who
6 probably could.

7 **MR. ORTIZ:** Well, actually when I called you
8 people at NIOSH -- okay? -- there was a fellow who
9 sent me a booklet -- okay? -- with the orange cover
10 on it and he said there was no reason for me or
11 others to have gotten sick then 'cause you people
12 had a handle as to what the solvents would do to a
13 person, and that's I guess what I'm asking also. I
14 mean how could things like this be allowed for an
15 employer not to care?

16 **DR. ZIEMER:** This group probably doesn't
17 know the answer to that, and in fact we're trying to
18 address -- trying to address some remedies for some
19 things that occurred in the past that unfortunately
20 have had some adverse effects. And the object is to
21 try to fairly address those. Certainly on an
22 individual basis we want to make sure you're pointed
23 in the direction --

24 **MR. ORTIZ:** All right.

25 **DR. ZIEMER:** -- where that can be done.

1 **MR. ORTIZ:** I would like to talk to someone
2 that --

3 **DR. ZIEMER:** I don't know if -- Shelby, if
4 you can --

5 **MR. HALLMARK:** Somebody's just given me a
6 card.

7 **DR. ZIEMER:** Okay, so we'll try to help this
8 gentleman get underway in the right direction.
9 Thank you very much.

10 **MR. ORTIZ:** Okay, thank you.

11 **DR. ZIEMER:** Thank you, Ben. Then Ken
12 Silver, and Ken, you can introduce yourself
13 background-wise.

14 **MR. SILVER:** Yeah, I met Mr. Ortiz in the
15 spring of '99 and we decided we'd try to get folks
16 together around this issue since Bill Richardson got
17 most of his education on these issues around here.
18 Mr. Ortiz and many others have already been through
19 the New Mexico workers comp program and the local
20 Congressional offices are well aware that that's an
21 issue. Would the Department of Labor be friendly to
22 an increased appropriation to manage a single payer
23 system for other toxic chemical claims?

24 **MR. HALLMARK:** I'm sorry, I was --

25 **MR. SILVER:** Would the Department of Labor

1 be friendly towards a major increase in their
2 appropriations to manage a single payer system for
3 subtitle D claims?

4 **MR. HALLMARK:** I think you're referring to
5 the legislation that's been submitted by Senator
6 Bingaman, among others, to alter the part D program
7 and the Department of Labor I don't think is in any
8 position to make comments on that legislation.

9 **MR. SILVER:** All right. Well, I hope you'll
10 take the strong message back to Washington that it's
11 really the only thing that's going to help Ben Ortiz
12 and many other people here in New Mexico. They've
13 already been through the New Mexico workers comp
14 mill.

15 For the purpose of this Advisory Board,
16 though, you're doing these site profiles, and we
17 understand your mandate is really just radiation
18 exposure. But as long as you're in the record
19 series, interviewing people, doing one-of-a-kind
20 work that's never been done before, our
21 recommendation is that you keep a little
22 bibliography of useful sources of information about
23 toxic chemical exposures at Los Alamos and other
24 places, and make it public; don't just send it to
25 NIOSH, append it as a bibliography to your site

1 profile. And others will come along and build on it
2 as the subtitle D part of the legislation is
3 improved.

4 Another point that a person who's here today
5 asked me to raise is many people at Los Alamos also
6 had exposures in the test program in the Pacific and
7 the Nevada test site, and we understand that the
8 legislation is not very favorable towards combining
9 the doses. But for the record, a lot of people went
10 to work at Los Alamos. They incurred those
11 exposures in the Pacific, on the hill at the Nevada
12 test site, and you know, for another day the only
13 way those people are going to be able to get justice
14 if the doses can be added together.

15 When it comes to conflict of interest, one
16 of the reasons these problems have been insoluble
17 around here is that -- you've heard the expression
18 company town. Well, welcome to the company state.
19 A lot of the professionals who had the credentials
20 and training to help were essentially bought and
21 paid for already, and we are a little -- we are
22 quite concerned that Oak Ridge Associated
23 Universities is a major DOE contractor. And by
24 their own admission, they have major conflicts of
25 interest. There's a lot of knowledge and expertise

1 among former LANL workers that isn't reflected in
2 the formal models that health physicists use, so
3 we're going to be watching the dose reconstruction
4 process very carefully and make sure that the
5 workers, who are the real experts when it comes to
6 their work environment, are respected.

7 And if you set up an auditing system, as has
8 been proposed, John Till's* group and (inaudible)
9 are known quantities around here. They're known to
10 be people of integrity who already have
11 relationships and enjoy a high level of confidence
12 with the public, so I'd urge you to include them as
13 auditors in some part of the work that you're doing.

14 And finally, documentation of exposures in
15 work processes has been a huge bugaboo for everyone
16 bringing claims, especially the survivors. The
17 occurrence reports collection at Los Alamos is one
18 of the largest, most informative series.
19 Unfortunately it hasn't been available to the public
20 over the years. Dr. Andrade, I want to thank you
21 for the limited access I had a few years ago. I'm
22 wondering if you've had a -- if the lab has had a
23 chance to digitize that collection yet.

24 **DR. ANDRADE:** I believe it is digitized.

25 **MR. SILVER:** Well, that's good news. We

1 filed a Freedom of Information Act request this
2 morning for the entire collection, and we're going
3 to put it in the public domain and work with people
4 to add their own recollections to what has been
5 documented on the hill over the years and help
6 people pull together documentation for their claims.
7 Thank you for your time.

8 **DR. ZIEMER:** Thank you, Ken. I might
9 mention that in the past we have actually -- I
10 neglected to do this, to ask if any of the Board
11 members have questions to direct to those who make
12 public comment, so let me back up a minute and ask
13 if anyone has any questions for Jonathan or for Ben
14 or for Ken. I didn't mean to neglect to do that.

15 (No responses)

16 **DR. ZIEMER:** If not, then we'll proceed.
17 Next is Richard Miller. Richard? Now you may
18 publicly comment, Richard.

19 **MR. MILLER:** I feel unconstrained, Dr.
20 Ziemer.

21 **DR. ZIEMER:** Oh, no.

22 **MR. MILLER:** I knew you didn't want to
23 invite that.

24 This is probably going to be redundant with
25 your deliberations, but I'm also going to just put

1 it on the record because we happen to be blessed
2 with Senator -- I hope -- yes, Senator Bingaman's
3 staff is still here, and I think Congressman Udall's
4 staff is here or was here -- yeah, there we go,
5 great. And that is that if this Advisory Board is
6 not able to, shall we say, appropriately assist
7 NIOSH in getting additional FTE's, particularly to
8 help in the dose reconstruction process, maybe some
9 of those in the Congressional delegation could nudge
10 CDC to give you another 25 or so FTE's. Would that
11 be a good round number? Okay. With no objection --
12 without objection, so ordered. But it is -- it is
13 painfully -- just from being in the audience, it is
14 so painfully clear that with what at least was
15 represented at the last Advisory Board meeting that
16 there were four health physicists, I believe -- is
17 that correct? That you have on the NIOSH staff?

18 **MR. ELLIOTT:** Right.

19 **MR. MILLER:** That's an accurate number. And
20 you know, you look at 8,000 dose reconstructions,
21 the conflict of interest reviews -- I would actually
22 lose sleep if I were the director of OCAS with that
23 circumstance. I know you don't, Larry, but -- would
24 you care to comment?

25 **MR. ELLIOTT:** (Inaudible)

1 **MR. MILLER:** All right. In any event, to
2 the extent that this is really a huge issue that has
3 to be dealt with appropriately, and I guess we would
4 really defer to you on the best way to do it.
5 Congress did put some language in the Labor/HHS
6 bill. Probably -- who knows when we'll have a
7 Labor/HHS bill? It may not be for some time and so
8 it's not timely to solve your problem. How soon do
9 you need additional staff -- no, this is a serious
10 question. How soon? Like is this like something
11 you need to start hiring immediately or is this
12 something by January? How quickly does this need to
13 happen?

14 **MR. ELLIOTT:** I think the answer to your
15 question is very obvious, that as soon as the ORAU
16 team starts churning out dose reconstruction reports
17 on the order of 150 a week or more, we're going to
18 need help. I don't believe that Jim and the three
19 health physicists that we have on staff will be able
20 to accommodate a full-fledged review. So yes --

21 **MR. MILLER:** Great. The second question I
22 wanted to raise had to do a little bit with how
23 NIOSH will go about the implementation. We've heard
24 some discussion from Jim and others today about the
25 COI disclosures. How -- how will this work? The

1 conflict of interest statement in the contract says
2 sunshine is the best disinfectant, and yet we hear
3 competing concerns about Privacy Act considerations.
4 I don't know that anybody's asking for anybody's
5 home address or phone number, or their written
6 signature. But I guess getting around sort of those
7 obvious issues where we really don't think that's in
8 dispute and there are constantly public documents
9 with Federal officials' names on them. Here you've
10 got contractor employees carrying out the
11 activities, in effect, of the Federal government
12 because you don't have enough FTE's to do your -- to
13 do the mission that you've been tasked. And so I
14 would like I guess for the Advisory Board, when it
15 thinks about its work with NIOSH, to try to provide
16 for a level of transparency that is most simple for
17 claimants, that is as in-depth and as thorough as
18 possible, because I think at some level the right to
19 know by claimants outweighs the privacy rights of
20 the individuals not to have their resumes known when
21 they're doing the public's work.

22 Having said that, it'll ultimately become
23 public if these cases ever get litigated. And it
24 just sort of seems silly, you know, later for that
25 stuff to -- it would seem silly to withhold

1 information that ultimately becomes public later and
2 then suspicions rise and so -- you know, you've done
3 a good job on your web site. You've got a lot of
4 information out and I would just like to encourage
5 you all, because it is -- there's nothing in the
6 contract today that orders ORAU to make these
7 disclosures. The slides you put up today said if
8 NIOSH tells us to, we'll make this information
9 public -- if. And so it's conditional on you all's
10 action.

11 I think earlier today we heard a question
12 about what happens if there's a conflict of interest
13 challenge, and you would like it brought to your
14 attention so you could try to resolve it before
15 perhaps it might be appealed to the Labor
16 Department. What if -- do you have a procedure in
17 mind about how people would seek recourse? In other
18 words, if somebody thinks they've got a problem with
19 who's doing their dose reconstruction and they
20 actually do get this information, is there going to
21 be a phone number and a procedure of someone they
22 can call up, or are you going to have some process
23 for evaluating whether they're raising a credible or
24 a non-credible conflict concern? And then lastly,
25 are you going to give them the choice to -- if

1 they're still uncomfortable, even after they've
2 heard your explanation, and under what circumstances
3 would you give them choice to select perhaps
4 somebody else to do their work if it would raise
5 their comfort level?

6 **MR. ELLIOTT:** It's a three-part question.

7 **MR. MILLER:** You had a lot of sleep lately.

8 **MR. ELLIOTT:** Three-part answer. Yes, there
9 will be -- there will be a NIOSH point of contact
10 assigned to each claimant for each case file who
11 will be able to respond to concerns and questions
12 regarding how a claim is moving forward -- not only
13 conflict of interest, but where's my -- where's the
14 status of my claim, where's the DOE-submitted
15 information, how long has it been -- a variety of
16 things that the NIOSH point of contact, that's the
17 claims specialist that Jim mentioned before that we
18 call public health advisors.

19 As well, the ORAU team will have their
20 person who is also a mirror image of that. And so
21 they're going to have both of those points of
22 contact, the NIOSH point of contact, the ORAU team
23 point of contact. We will be working with ORAU and
24 their team to establish a policy procedure and
25 process that will be implemented to alert the

1 claimants that if you have a question about -- or
2 have a concern or have an issue regarding conflict
3 of interest, here's how you go about registering
4 that, and providing what your concern is to us so
5 that we can take some action to review and evaluate.

6 Now I've lost sleep 'cause I've lost the
7 third part of your question --

8 **MR. MILLER:** Which is what's the recourse?
9 I mean once they notify you, are they going to have
10 the option of being able to select somebody as an
11 alternative?

12 **MR. ELLIOTT:** No, the claimants do not have
13 an option to select their dose reconstructionist.
14 That's not on the table. And the reason for that is
15 is because we need to assign a dose
16 reconstructionist who has the skill and the
17 expertise to do that work, and we can't rely on a
18 claimant to understand, you know, from the pool of
19 available dose reconstructionists who might fit that
20 scheme, so that's not on the table.

21 What is on the table, though, is that we can
22 hear what the concerns and the issues are regarding
23 the dose reconstructionist who has been assigned,
24 and if we feel that that's a valid concern, we'll
25 reassign -- make a new assignment and put a new

1 person on top of it. I don't think there's going to
2 be any argument or quibbling about the validity of
3 that concern that's registered. We're just going to
4 take it and go with it and make a change.

5 **MR. MILLER:** Okay, so it's a no-quibble
6 policy. All right.

7 And then with respect to the disclosure that
8 came up today, that there are approximately -- it's
9 either 90 firms or 90 individuals that have been
10 retained by ORAU to do dose reconstruction?

11 **MR. ELLIOTT:** There's 90 individuals. There
12 are not 90 firms. Ninety indivi--

13 **MR. MILLER:** That was a bit confusing
14 earlier.

15 **MR. ELLIOTT:** Ninety individuals. I
16 believe, am I right, Mr. Toohey? Yeah, Dick -- Dr.
17 Toohey?

18 So there are 90 individuals who have been
19 identified to date that are ready to serve as a dose
20 reconstructionist, not 90 firms.

21 **MR. MILLER:** Okay. And how many firms are
22 there? Are there just the three?

23 **MR. ELLIOTT:** Dick, you want to --

24 **MR. MILLER:** Dade Moeller and MJW and
25 yourselves?

1 **DR. TOOHEY:** No, we have three or four other
2 what we call resource subcontractors -- ENSR,
3 Research Associates, maybe one -- and another one
4 that I just can't think of. I know we did submit
5 with the proposal that NIOSH has what was a measles
6 chart listing of names, education, experience and
7 qualifications (inaudible).

8 **MR. MILLER:** Well, since Larry's
9 anticipating my next question, which is disclosure,
10 one of the things that was included in the NIOSH
11 contract was it incorporated the bid proposal by
12 reference. Is that -- is there a plan at some point
13 to make that public in some form?

14 **MR. ELLIOTT:** Yes, we're working toward that
15 end. However, there's been a -- we have to go back
16 to the ORAU team. They're being asked to review
17 their proposal for proprietary information that
18 would give an unfair competitive advantage for
19 future bidders on a similar statement of work that
20 we might let in the future. So once we have that
21 established through our legal process to remove
22 those kind of things, it will be put out.

23 **MR. MILLER:** So -- and with respect to the
24 posting of the other subcontractors, is that going
25 to be posted on your web site, as well? Or how will

1 that be made known outside this room?

2 **MR. ELLIOTT:** Well, it's in the proposal,
3 but it -- once we come up with how we're going to
4 place -- I think on ORAU's web site -- who the dose
5 reconstructionists are, it'll be very apparent what
6 their work histories have been and who they've been
7 -- who they're currently affiliated with, who
8 they've been affiliated with in the past.

9 **MR. MILLER:** All right. And I just -- my
10 last comment has to do with your Section 3152
11 report. I heard Grady say that he's planning on
12 contacting corporate enterprises and I guess other
13 DOE sources of information. Can we just make a
14 small suggestion, which is if you're going to try to
15 fill in the gaps on the data, there are a bunch of
16 other sources, including workers. There's been no
17 community outreach on this up to this interim
18 report. It would be helpful if there was some
19 outreach to try to capture knowledge. There are
20 Congressional offices with file drawers of
21 information, some of whom are leaving Congress this
22 year, who -- on some of these facilities, which is a
23 rich mother lode. You have some people on this
24 committee who have actually worked on individual
25 facilities that need additional data that could be

1 your data source. And there's the state regulatory
2 agencies. And so I don't know if it's going to be
3 doable if you have a report due to Congress on the
4 28th of December to do all that, but I would just
5 encourage some outreach.

6 **MR. ELLIOTT:** Your suggestion has been
7 provided before. It's been well taken. We
8 understand what you propose to us in that
9 suggestion. It's not a -- in Grady's list of where
10 we're going to go next in further investigation. It
11 was perhaps an oversight, but we do intend, once we
12 get down to a specific site where we need more
13 information, we're going to focus and target where
14 we can get that, and that's when we'll engage those
15 other kinds of sources of information.

16 **MR. MILLER:** Thank you for clarifying that.

17 **DR. ZIEMER:** Let's see, I have next -- I
18 think it's Jerry Lada -- is that -- do I pronounce
19 that correctly, Jerry? From Espanola, New Mexico.
20 Jerry.

21 **MR. LADA:** Good afternoon, ladies and
22 gentlemen. I want to welcome all the CD to Santa
23 Fe, New Mexico where I was born and raised. Welcome
24 to the state of the Land of Enchantment.

25 I worked as a RCT, radiological control

1 tech, for the Los Alamos National Laboratory for a
2 number of years, worked with plutonium 238, 239,
3 americium 241, cobalt 60, cesium 137, and I'm now in
4 the process of going through medical evaluation,
5 hopefully with the National Jewish Hospital in
6 Colorado.

7 The three issues that I want to address to
8 you is, one, the IREP model. I don't understand why
9 you're taking atomic data that we used in Japan when
10 we did the bombing for Hiroshima and Nagasaki
11 because a lot of the scientific data does not really
12 apply to nuclear workers around the United States.
13 And I think they should use the data that is used at
14 nuclear facilities around the country, the 12
15 nuclear facilities that under Department of Energy.

16 The second issue is the conflict of interest
17 with Oak Ridge. I think, as Ken and Richard
18 expressed, that there is a conflict of interest and
19 they admitted it themselves, also. And for auditing
20 purposes I would like to know, as a taxpayer, my
21 money going -- when the claimant should have the
22 right when the caseworkers assigned to him or her
23 that they should know through the whole process what
24 is going on with their -- the dose reconstruction.

25 The third issue that I want to address is

1 Los Alamos National Laboratory becoming a special
2 cohort exposure (sic). What are the guidelines,
3 what's going to be the petition for Los Alamos
4 National Laboratory for it to become a special
5 cohort exposure (sic)?

6 I feel, as a representative of the union at
7 Los Alamos National Laboratory -- we don't have a
8 contract yet, but we're UPTE, University
9 Professional Technical Employees, TWA 9119 out of
10 California for Berkeley, Santa Cruz, a lot of the
11 different -- there's 10,000 strong members and right
12 now we're organizing at Los Alamos National
13 Laboratory.

14 And I feel that -- when I talked to the guys
15 who worked at TA-55, they're intimidated by
16 management. I asked them how come you guys haven't
17 filed a claim? Oh, Jerry, we can't do that. Why
18 can't you? I'm afraid to lose my job.

19 Director John Brown came out with a memo to
20 all the employees that no employee will be
21 retaliated if they file a claim for the energy
22 illness compensation act. But still a lot of these
23 guys are scared. And I see them -- people like
24 custodians, staff members, technicians, security
25 guards -- 28 people that I know that have died. One

1 of my neighbors, Mariano (inaudible), he was an RCT.
2 He died from cancer. One of my friends father,
3 Senor Antonio Garcia, I know worked at Los Alamos
4 National Laboratory for many years and has cancer.
5 He goes to John (sic) Hopkins University School --
6 the medicine where they take the physical at
7 Espanol. They tell him nothing's wrong with him.
8 Nothing's wrong with him. He's not the first case.
9 So I think John (sic) Hopkins is losing credibility
10 here.

11 Also the Department of Energy, the brochure
12 I received to go get a medical review or a medical
13 exam, but not both of them because of budget
14 constraints. Well, what good is the study for if
15 they're just going to refer you to another primary
16 physician? Right now I'm trying to get my HMO, Blue
17 Cross-Blue Shield, to approve this visit to the
18 National Jewish Hospital in Denver. It's only been
19 five weeks. I still can't get an approval.

20 So I'm asking NIOSH -- there's a lot of work
21 that you guys still have to do because, as a
22 Hispanic person who was born and raised here, a lot
23 of my cousins, uncles, aunts, grandpas and grandmas
24 who have worked on Los Alamos National Laboratory to
25 do the dirty work from glow boxes and cleaning pipes

1 that are leaking with plutonium 238 and have gotten
2 sick.

3 This is a program for the people. The money
4 was set aside for the people to be compensated. The
5 burden of proof is upon the claimant. Once they
6 have one of the 22 known cancers, then they have to
7 go through all the hard work, all the paperwork, all
8 the medical work and then just to get shut down. I
9 think this is b.s., Larry.

10 And it hurts me that I see my family, my
11 Hispanic people, Anglo people, Native Americans and
12 black people who have died from cancer and are
13 suffering now. \$150,000 is nothing for a human
14 life, nothing. It is your duty, 'cause these people
15 gave their duty to their country. They fought for
16 freedom. It's time for you guys to help these
17 Americans out.

18 It's a shame that we can give hundreds of
19 millions of dollars to other countries around the
20 world, but we can't pay our own American people who
21 have gotten sick, who have cancer, working for
22 nuclear facilities. Thank you.

23 **DR. ZIEMER:** Thank you, Jerry, and let me
24 ask again if any of the Board members have questions
25 for Jerry. Your comments will be on the record,

1 Jerry.

2 **MR. LADA:** Thank you.

3 **DR. ZIEMER:** Let's see, I've got another
4 sheet here. I think we've had some additional folks
5 come in. I'm having a little trouble reading this.
6 Is it Epifamia?

7 **UNIDENTIFIED:** (Inaudible)

8 **DR. ZIEMER:** Yes. Would you like to speak?
9 You need to use the microphone. You need to
10 identify yourself and --

11 **MS. SHINUS:** I'm sorry, my name's Bettie
12 Jean Shinus. I'm a survivor and my father worked
13 for (inaudible) company and he worked there for 35
14 years. He's deceased. And my sister couldn't be
15 here and she asked that I ask something of the
16 panel.

17 There's a questionnaire on the internet
18 right now that's going to be asked of the survivors.
19 Are you aware of that questionnaire that I'm
20 speaking of? It relates -- doesn't relate to
21 anything that we can answer. Absolutely there is
22 not one question I could, as a survivor, answer.
23 And the question my sister had is are you going to
24 revise that for the survivors or what? Because
25 there's not one question on that that -- as a

1 survivor, that I could answer. And she wanted to
2 know that.

3 **DR. NETON:** The questionnaire was crafted
4 with the idea that all the questions were related to
5 helping us to determine what the exposures were to
6 the workers, and so that's why they tend to be
7 somewhat technical in nature, and we do expect that
8 many of the survivors will not be able to answer
9 them. But we felt it necessary to have them on
10 there in case that information would be available.

11 That being said, we do ask at the end of the
12 questionnaire for any information on co-workers who
13 would be knowledgeable or others to shed some light
14 on the exposure scenarios or profiles or experiences
15 that the person would have underwent at that
16 facility. So they're really just there as an
17 attempt to gather sufficient information for us to
18 do some type of a dose reconstruction. And by that
19 nature, they're somewhat technical. And I don't
20 know that we can craft another questionnaire that
21 would provide us the same type of information that's
22 somewhat simpler, although we are definitely open to
23 feedback on that questionnaire.

24 **MS. SHINUS:** I don't think it's because it's
25 technical that we can't answer it. We can't answer

1 for my dad. We don't work there. We didn't know
2 who he worked with. How can we answer that. It's
3 been -- how many years, Epi? It's been 20 years
4 since he died. There's no way.

5 There was something said about dose
6 reconstruction. Does anybody here -- has anybody
7 here worked at Los Alamos? Well, I can tell you,
8 you've been exposed. I mean, to me, there is no
9 question in my mind. I have a brother that works
10 there. I have a nephew that works there. And I
11 know that they've been exposed. I know my father
12 was exposed. Doesn't -- I don't have to be a
13 physicist to figure that out because I know the
14 safety -- what needed to be in place was not there
15 when my father worked there. My father was a sheet
16 metal worker. He worked -- contracted to the labs
17 and we have pictures of my dad working there at the
18 labs, working with all that piping, with no safety
19 gear at all. I know my dad was exposed. He died of
20 cancer -- died of throat cancer.

21 I guess my question is to you can you prove
22 that he wasn't exposed? Not that he was exposed,
23 that he wasn't? 'Cause I know that -- you cannot
24 convince me that everything was in place to make it
25 safe for my dad to work there. My dad had six kids

1 to support. He didn't question whether it was safe
2 or not. He put that faith in the labs and where he
3 worked. And what I'm hearing now is he put his
4 faith in the wrong place. My dad was very -- the
5 type of person that lived for his work and gave
6 everything to his job. But he had a family to
7 support and he did it with love, never complained a
8 day in his life, never retired. He worked for 35
9 years for (inaudible) company. And I feel like
10 we're put -- being put in a place to defend that and
11 to prove what, that my dad didn't work at Los
12 Alamos? He worked there for 35 years. Prove to me
13 that he wasn't exposed.

14 I've read some of my dad's records and I can
15 tell you he was. But what -- I mean to have to put
16 that into your hands to determine just how much
17 exposure really counts. To me, if he had cancer and
18 he worked there, that's a given to me, and that's
19 all I have to say as his daughter.

20 **DR. ZIEMER:** Thank you, and -- is it a
21 sister or --

22 **MS. SHINUS:** We're all siblings.

23 **DR. ZIEMER:** Siblings, okay. Thank you.

24 **MS. JACQUEZ:** My name is Epifania Jacquez
25 and I am Bettie Jean Shinus's sister and there's

1 (inaudible) siblings and we are the survivors. We
2 were the people that was -- that were I guess
3 eliminated from the program the first time around,
4 and we're very pleased that Jeff Bingaman and Ken
5 Silver and Tom Udall and a lot of people worked on
6 our behalf. My sister and I also, we hung in there
7 and didn't give up because we knew about my dad and
8 we are survivors.

9 I have a couple of questions that I want to
10 ask -- I didn't come here -- I understand you had
11 your meeting and then it was open for public comment
12 for about an hour, so -- but I guess we weren't
13 allowed at the -- you know, while you guys were
14 having your meeting, the scientists. And not being
15 scientists --

16 **DR. ZIEMER:** No, let me -- the meetings are
17 all open, yes.

18 **MS. JACQUEZ:** Okay. Well, the notice that I
19 got, it said that the public -- it was open to the
20 public from 3:45 on but that your meeting started at
21 8:30. I got --

22 **DR. ZIEMER:** I'm sorry you --

23 **MS. JACQUEZ:** That's how I was informed.

24 **DR. ZIEMER:** All of the meetings are
25 completely open to the public. This period is open

1 for public comment, but --

2 **MS. JACQUEZ:** Oh, I didn't know that. I
3 would have been there.

4 **DR. ZIEMER:** These are not closed meetings.
5 I'm sorry that that was not communicated to you.

6 **MS. JACQUEZ:** That's how I understood it.
7 But as --

8 **DR. ZIEMER:** And the meeting tomorrow is
9 also open. You're certainly welcome to attend.

10 **MS. JACQUEZ:** I do have a question for all
11 these scientists that are here, and I'm going to ask
12 you -- I want to ask, should any individual or any
13 person be exposed to high levels of contamination?
14 Should anyone be exposed? Should anyone be exposed?
15 I'd like an answer for that.

16 **DR. ZIEMER:** No.

17 **MS. JACQUEZ:** Good, okay. And if the answer
18 is no, so if a person is exposed about seven to nine
19 times, is that a bit too much? If someone is --

20 **DR. ZIEMER:** Well, you're asking a technical
21 question that does not have one single answer. Many
22 of us have worked with radiation all our lives,
23 including me, so --

24 **MS. JACQUEZ:** But have you been exposed?

25 **DR. ZIEMER:** Oh, of course.

1 MS. JACQUEZ: You've been exposed to --

2 DR. ZIEMER: Of course.

3 MS. JACQUEZ: -- high levels of radiation?

4 DR. ZIEMER: Of course.

5 MS. JACQUEZ: Do you have cancer?

6 DR. ZIEMER: No, I don't.

7 MS. JACQUEZ: You're lucky. Anyway --

8 DR. ZIEMER: But you know, one of the things
9 -- let me just comment that we're charged by
10 Congress to do is try to establish how much exposure
11 an individual's received. You used numbers -- one,
12 two, three, nine. We use some dose numbers, but
13 they relate to the numbers of times exposed. And
14 you know, the law's written in a certain way that
15 does provide compensation at certain levels. And
16 our Congressmen have established that law. We may
17 not agree with its complete provisions -- you know,
18 is the money enough, is the level at which
19 compensation is given the right one -- but currently
20 it's the law and this Board is charged with trying
21 to assure that that law gets carried out by the
22 agencies in a fair way, and that's what we want to
23 do. So -- and we're certainly sympathetic. There
24 are so many individual cases, each one's a little
25 different. But the effort is to treat them fairly,

1 try to establish the extent to which that exposure
2 makes them eligible under the Congressional mandate
3 that we have received. And this Board nor the
4 agencies can operate differently from what our U.S.
5 Congress has charged us to do. So you appreciate
6 that.

7 **MS. JACQUEZ:** I do. And I'm also aware that
8 there was a rating, you know, as you go from a low
9 to a high and next to a high is a moderate, and I
10 think moderate is high. What is your opinion, as a
11 scientist, if you get moderate exposure repeatedly?
12 I think that's pretty high.

13 **DR. ZIEMER:** It may be in some cases.

14 **MS. JACQUEZ:** It may be in some cases? I
15 think it is actually. I can't imagine how you would
16 imagine that it wouldn't be in all cases, but that's
17 just my opinion.

18 And I'm wondering, I don't -- there's a lot
19 of times that these workers were not monitored, you
20 know. You have a worker that worked in all -- you
21 know, in all the buildings, and in some of the hot
22 spots in Los Alamos. My dad worked there, and not
23 always were they protected or were they monitored.
24 And so I have also -- it is my understanding that
25 the r-e-m has been set at five. Am I correct?

1 That's what you're using?

2 **UNIDENTIFIED:** (Inaudible)

3 **MS. JACQUEZ:** So if a worker has 4.4
4 something, do you take that into consideration,
5 considering that they weren't always monitored? Are
6 you -- you know, being as to how you're going to be
7 very fair and very compassionate towards these
8 workers, and you're looking at a worker that has
9 worked for 35 years?

10 **DR. ZIEMER:** We don't want to get into a
11 long dialogue, but let me say -- and I'm sorry that
12 you missed the earlier part of the meeting because
13 in fact the NIOSH staff has shared with us a number
14 of cases that they've already processed where they
15 have situations very similar to what you're
16 describing. One of the jobs NIOSH does in the dose
17 reconstruction is in fact to identify missing dose
18 and they are very -- let me call it worker-friendly
19 in assigning numbers based on related data,
20 monitoring data where there's missing information.
21 But -- and perhaps that can be shared with you
22 later, but you're quite right. There are many cases
23 that will come before this group where there are
24 pieces of information missing. And the question is,
25 how do you treat that, and we're trying to do that

1 in an equitable and fair manner.

2 **MS. JACQUEZ:** Okay. And we do have
3 documentation of my dad's exposure, so I'm very much
4 aware --

5 **DR. ZIEMER:** That would be very helpful.

6 **MS. JACQUEZ:** And we have already filed our
7 claim. I have one more question before I ask you my
8 final question, and that's -- just curious. Let's
9 say a scientist that worked in Los Alamos, how
10 protected were they when they were working, compared
11 to other workers? Because we've heard horror
12 stories. Did they wear suits? I know that they
13 were extremely well-educated, especially -- that's
14 going back 21 years. You had your craftsmen and
15 then you had your scientists. My guess that there'd
16 be a large amount of those scientists that knew the
17 dangers that probably were protected or knew how to
18 protect themselves. And also the fact that in Los
19 Alamos -- and this is stuff that I've heard or
20 information that I've heard -- they were shredding
21 evidence -- evidence that -- you know, they were
22 shredding papers and records and everything. And at
23 the beginning you were told that there weren't any
24 records to be found. So Los Alamos is one of those
25 labs where that was going on, and I don't believe

1 that the workers -- this is my opinion, that the
2 workers at that time worked in Los Alamos didn't
3 share that much with their families and felt very
4 fortunate that they had a job in Los Alamos. At
5 that time Los Alamos paid good salaries, but I don't
6 think that they were very well informed about the
7 dangers of working out there. You know, this has
8 only happened in say, what, the last five years,
9 that we've become so aware of the dangers that were
10 out there?

11 For my dad, who was very dedicated in his
12 job, extremely dedicated in his job, we're going to
13 hang in there because my dad believed in his country
14 and this compensation act is a compensation act.
15 And like someone said, what's \$150,000, you know,
16 for a life? My dad died fairly young. That is not
17 a lot of money. It doesn't replace a person that
18 you've lost.

19 And so one final question or comment and
20 that would be the timetable. Okay? What is the
21 timetable? Let's say if you filed a claim and it's
22 been six or seven months that you filed your claim
23 and they have all the paperwork. Your father's
24 dead. He's deceased. Is there a timetable? Are
25 you putting any kind of timetable for this program

1 to come to fruition? I mean even a guess? I know
2 that the government has money to pay for this.
3 We've been told that money is not an issue. I have
4 that as a quote from one of your top officials. So
5 supposedly it's not the money. Then why is it
6 taking so long? If we can in a moment turn around
7 and finance a war to eliminate Hussein -- and I'm
8 just going to use that as an example -- and it
9 probably -- happen within two weeks, why something
10 like this that affects American citizens, people
11 that have given up their lives, that have worked for
12 something they believe in, their government, why is
13 it taking so long? Why should it continue to take
14 so long? And as far as a timetable, could you
15 answer that for me?

16 **DR. ZIEMER:** Great question. I think we all
17 wonder some of these -- philosophically about where
18 priorities are in our government sometimes.

19 Specifically on the timetable, there are a
20 couple and Department of Labor has some specific
21 timetables which in fact they shared with us this
22 morning to make us aware, and NIOSH had some
23 timetables, and perhaps the staff can comment on
24 that.

25 **DR. NETON:** Yes, this morning we went over

1 some of the -- we just brought on board on September
2 11th a dose reconstruction contractor to assist us
3 in performing these dose reconstructions. The
4 provisions of the contract call for up -- at least
5 8,000 dose reconstructions to be conducted per year.
6 So assuming that your father's claim is less than
7 8,000, it would be processed hopefully in the next
8 year. Do you happen to know the claim number?

9 **MS. JACQUEZ:** I have it at home.

10 **DR. NETON:** That also being said, the -- it
11 does depend on us having a complete record from the
12 Department of Energy to complete the dose
13 reconstruction, or at least sufficient for us to use
14 our process on that claim. You know, not knowing
15 your father's specific claim, I don't know that we
16 actually have all of the information at hand. We
17 do? Well, if that's the case, we've asked our dose
18 reconstruction contractor to go through all the
19 claims starting with number one and identify those
20 claims where sufficient information exists and to
21 make them a priority to process. So not knowing
22 where your claim is in the system, I'm fairly
23 optimistic that if we can meet our goal of 8,000, it
24 will be accomplished in the next -- within the next
25 year. But it could be much sooner than that. I

1 don't want to give you the impression that it could
2 be a year.

3 **MS. JACQUEZ:** Okay. So then I can say that
4 perhaps -- me being a survivor and I'm 63 years old
5 -- that it won't go on to my children, another --
6 another set of survivors.

7 **DR. NETON:** I hope not.

8 **MS. JACQUEZ:** Thank you for listening to me.

9 **DR. ZIEMER:** Thank you very much. Are there
10 any other members of the public -- another comment?
11 Sure.

12 **MS. SHINUS:** I'm sorry.

13 **DR. ZIEMER:** No, that's fine. Please.

14 **MS. SHINUS:** And I only come up here because
15 I'm speaking for my sister and myself, so I figure
16 that's two people. When I asked that question about
17 the questionnaire, I didn't get an answer back, I
18 don't think. My sister wanting to know -- this --
19 you know, it's an assessment tool. I mean this is
20 an assessment tool, what -- this questionnaire. We
21 can't answer -- I'm not kidding you, we cannot
22 answer one of these questions. So I'm saying if
23 it's an assessment tool, that may be negative
24 towards our --

25 **DR. ZIEMER:** Again, I think we can have the

1 staff answer that. Note that there are some
2 survivors that have that information, and where they
3 do, they want to make sure to get it. But I think
4 it's understood that many will not. But you're
5 quite right, and particularly in the early days,
6 much of this work was sort of secret and the workers
7 weren't supposed to talk about it at home, so you
8 didn't know about it. Plus a lot of men just don't
9 talk about their work. You know, wives are kind of
10 -- what are you doing; they don't tell them. Who
11 wants it -- Larry?

12 **MR. ELLIOTT:** I think Jim answered your
13 question, but maybe you didn't hear it or you -- it
14 was misunderstood. We fully expected that that
15 survivor questionnaire would not be beneficial for
16 all survivors. But hearing you talk and hearing
17 your sister talk, you have pictures, you have
18 photos, you have dose records, you have information
19 about what your dad did. You knew he was a sheet
20 metal worker. You knew he worked on duct work and
21 where he worked, perhaps. That's information that
22 is beneficial to our dose reconstruction process.
23 It's information that would come out in the
24 interview. Maybe it's not a question specific in
25 that questionnaire, but it's information that will

1 be elicited or obtained during the conversation with
2 the interview person that would conduct the
3 interview with you all.

4 The questionnaires have to go through a
5 approval process that is very rigorous for the
6 Paperwork Reduction Act with the Office of
7 Management and Budget, and it takes a good deal of
8 effort and time and resources to modify those
9 questionnaires. As Jim said, if you have -- we
10 welcome input on the content of the questionnaires
11 or the difficulty in understanding them, recognizing
12 that this whole process has a technical basis to it.
13 And unfortunately, they do have to speak to
14 technical things and so -- Jim I think wants to add
15 --

16 **MS. SHINUS:** Again, I want to say it's not
17 the technical piece of it. I've read it. I've got
18 it right here. It's very straightforward. It isn't
19 about that. It doesn't relate to survivors. It
20 relates to a person that's living, not to a
21 survivor. My dad's been dead for --

22 **DR. NETON:** I would say that we do accept
23 and encourage any of this additional information to
24 be provided at the time of the interview to us. A
25 number of people have done that where if they feel

1 the dose reconstruction interview does not
2 adequately capture their situation or their father's
3 situation, they will provide us in writing a
4 detailed description of what they believe to be the
5 case, and that will be added and stapled right to
6 the back of that interview form and considered at
7 dose reconstruction time. So that is not the only
8 piece of information that is used for the dose
9 reconstruction. There is numerous other pieces and
10 claimant-provided or survivor-provided input is
11 encouraged, and we will consider that. If you have
12 that information, please sent it to us.

13 **MS. SHINUS:** Okay. So the answer to my
14 sister is no, there is not a separate questionnaire
15 for survivors. It's --

16 **UNIDENTIFIED:** Yes, there is.

17 **MS. SHINUS:** Oh, there is?

18 **UNIDENTIFIED:** (Inaudible) right version.

19 There are two versions.

20 **DR. NETON:** Well, there is a separate
21 questionnaire, but in reality they are very similar
22 in their lines of inquiry.

23 **MS. SHINUS:** This is what I have. You can
24 -- whoever can tell me if this is it. And also is
25 there a Richard from the sheet metal workers here?

1 Richard? You work for the sheet metal workers?
2 This is a question from my sister. It asks -- oh,
3 go ahead.

4 **DR. NETON:** In looking at this, this appears
5 not to be a survivor interview. It talks about
6 reviewing of records of jobs you have held, so this
7 is specific to a claimant. However, I will --

8 **UNIDENTIFIED:** An Energy employee.

9 **DR. NETON:** An Energy employee, rather. I
10 will say, though, that the script is not -- there
11 are differences tailored to the survivor, but there
12 are similar questions on here because they are still
13 trying to elicit something about the dose, the type
14 of work.

15 **MS. SHINUS:** So there is a different one?
16 There is a different one?

17 **UNIDENTIFIED:** Yes.

18 **MS. SHINUS:** And she can access it through
19 the internet. Is that correct?

20 **DR. NETON:** I don't know that the
21 survivor --

22 **MS. SHINUS:** 'Cause that's where she got
23 this.

24 **DR. NETON:** -- is on the internet.

25 **DR. ZIEMER:** I'd like to ask -- particularly

1 since you may be asking questions specific to your
2 case and you want to ask Richard something --

3 **MS. SHINUS:** Yes.

4 **DR. ZIEMER:** -- I wonder if it would be
5 appropriate if you did that privately, since we
6 don't generally --

7 **MS. SHINUS:** Well, the thing is, it isn't
8 private because everything that I'm saying today --

9 **DR. ZIEMER:** It has a general --

10 **MS. SHINUS:** -- it isn't just for my dad.

11 **DR. ZIEMER:** Okay.

12 **MS. SHINUS:** I feel that I am speaking for
13 those people that can't be here, and those are the
14 people that are dead that have worked at the labs.
15 I feel I am one of those children, one of the family
16 members that is speaking for these families that are
17 out there and I have -- from the very beginning have
18 said that if we don't get a penny for me, the
19 important is for speaking for these families that
20 don't have a voice. I am a voice for some of those
21 families.

22 Richard, my question to you is this. ...
23 asking if we know of any people -- I'll read you
24 what my -- 'cause she wanted this specifically for
25 you. She said if you talk to Richard from the sheet

1 metal workers, ask if there's any way we could
2 contact or get a list of living workers to help in
3 the application process. Let him know that we have
4 charter listing workers. In other words, we have
5 access to that.

6 **MR. ESPINOSA:** Yes, in the back there's a
7 (inaudible) of sheet metal workers, Local 49 in the
8 -- to answer your question, yes. In the time period
9 that your father worked in Los Alamos we still have
10 a -- keep their Local senior that's still alive that
11 could probably help answer a lot of your questions,
12 and a few other workers that are in the Espanola
13 area and Santa Fe area, the Romero family and quite
14 a bit of other people that will be able to help you.

15 **MS. SHINUS:** So there is a few still living.

16 **MR. ESPINOSA:** Yeah, there's a few still
17 living.

18 **DR. NETON:** I would like to point out that
19 NIOSH is not asking you to contact those people and
20 provide that information to us. It would be
21 sufficient if you just provided the names of those
22 people and we would contact them and conduct those
23 interviews. However, you're free to do that
24 yourself, as well, but it's not -- the burden is not
25 on the claimant to contact the co-workers and obtain

1 the information. We will do that for you if you
2 desire.

3 **MS. SHINUS:** I have only one more comment,
4 and thank you for your time. I think many of the
5 people -- employees that are still working in Los
6 Alamos do not have a voice. I know my dad would not
7 be here today if his job depended on supporting his
8 family, so it is not that easy to come forward when
9 you're an employee, and I have family that works
10 there right now. So I want to thank you for your
11 time and I really appreciate your time and your
12 effort. Thank you so much.

13 **DR. ZIEMER:** Thank you. Maybe your sister
14 has another comment.

15 **MS. JACQUEZ:** I have a comment to make. If
16 I have submitted a claim and you have the dosometry
17 (sic) readings and you have exposure records, I'm a
18 survivor, my dad was the employee, why are you
19 asking me questions that you have answers to?

20 **DR. ZIEMER:** I'll let the staff answer that,
21 but in part it's because we believe there may be an
22 incomplete record in many cases that we want to fill
23 in the gaps, and you've already alluded to that, so
24 there are the dosimetry records, but we're really
25 saying is there additional information that we don't

1 know about and --

2 **MS. JACQUEZ:** But if you have enough in
3 front of you, I can't imagine -- I mean, you know,
4 let's say --

5 **DR. ZIEMER:** Oh, we had such a case this
6 morning. If there's enough information that
7 demonstrates that the claim requirements have been
8 met without the additional, then the claim is
9 approved without all that. Jim, you --

10 **DR. NETON:** Well, Dr. Ziemer's exactly
11 correct. However, we are committed in our rule to
12 interview every individual claimant, and so we do
13 contact them once we receive the Department of
14 Energy information, just as Dr. Ziemer indicated, to
15 ensure that the record accurately reflects the work
16 conditions. A person, however, does not have to
17 have an interview. One merely has to state that I'm
18 not interested in being interviewed, and that's the
19 end of it. So it's not a requirement to move the
20 claim forward.

21 **MS. JACQUEZ:** Okay. I cannot see, and I
22 think I'm a fairly intelligent person -- and I'm not
23 a scientist, but I'm a fairly intelligent person,
24 but as a scientist or as a doctor, if I had
25 documents giving me dosometry (sic) readings, I

1 would think that that'd be enough for me to
2 determine it, since you have a certain scale that
3 you're using. And for the claimants, to expect
4 answers from them, and I mean how can you answer for
5 that worker that wasn't there. You weren't -- you
6 weren't in -- you didn't walk in his shoes. They
7 didn't come home and tell you exactly what happened
8 at work. And we know of instances where he was
9 exposed, but my dad was not one to come in and
10 discuss his job with you. So I'm saying I have to
11 tell my sister, the one that asked this sister to
12 ask this question, my God, if that's -- if I get
13 called and I get thrown these questions -- which I
14 thought they were -- they didn't pertain to me. I
15 couldn't answer them. She kept saying well, these
16 are the questions that are going to be asked of you.
17 I said I'm not my dad. I can't answer them. So
18 these cannot be questions that are going to be asked
19 of us because that is silly. We weren't there. We
20 were not at his job. So to me, that's just
21 complicating an issue more, and I always say hey,
22 look at the simplicity. Get down to simple facts,
23 you know what I mean? A person is working in Los
24 Alamos. A person is exposed, is working in hot
25 spots, has a certain amount of exposure repeatedly,

1 what else do you want from the family when it's
2 documented right in front of you? And thank
3 goodness we have those documents.

4 **DR. ZIEMER:** Thank you very much. Are there
5 any other members of the public who have comments?
6 Okay, we have one lady here and then --

7 **MS. TRUJILLO:** My name is Gloria Trujillo
8 and I'm the oldest sister of my dad's family. I
9 don't have very many comments, but you did mention a
10 while ago that the workers were not supposed to talk
11 to their families. I'm the oldest and I was old
12 enough at that time that when my dad did come home
13 after exposure, he would tell my mom. They had to
14 do a complete change of clothing and all these
15 different procedures that they had to do on him, and
16 this was very often. I don't know how much -- how
17 many reports we actually have that have -- prove
18 that. You know, they may not all have been
19 documented. I don't know.

20 I have one question for you on -- 'cause
21 that's not clear in my mind. You have a certain --
22 I think it's five rems of exposure that you're
23 basing the -- your determinations on, more or less.
24 Will you have -- or is there a cumulative effect of
25 nuclear exposure?

1 **DR. NETON:** Okay, I think this was alluded
2 to in a previous commenter, the five rem of exposure
3 is the current regulatory limit -- annual regulatory
4 limit for a worker in a Department of Energy. We
5 don't -- that is not what we use to determine a
6 person's dose or their probability of cancer or
7 anything like that. We are totally independent of
8 that and use this model, this -- it's called an IREP
9 model -- to take the person's exposure as we
10 calculate it the best we can, given input from the
11 claimant and the Department of Energy to determine
12 the probability that the cancer was caused by an
13 exposure.

14 The second part of your question is yes,
15 cumulative exposure -- the larger the exposure, the
16 larger the probability the cancer was caused by that
17 exposure.

18 **MS. TRUJILLO:** I have one more question and
19 it's medical. There are certain types of cancer
20 that are, you know -- that are rare in the whole
21 population. My father had cancer of the esophagus,
22 which is, you know -- are you basing it on the types
23 of cancer? Say someone had lung cancer, someone had
24 cancer of the esophagus, are you taking that into
25 consideration, the type of -- where it's at, the

1 organ that it's affected?

2 **DR. NETON:** Yes, absolutely. Not only -- we
3 calculate the dose, the specific organ that
4 developed cancer, and as well use a model that was
5 specifically modeled for that type of cancer, so
6 that is taken into account.

7 **MS. TRUJILLO:** Thank you for your time.

8 **MR. ELLIOTT:** And now I think -- Dr. Ziemer
9 had to step out, so I get the mike and Bob Tabor
10 would like to speak.

11 **MR. TABOR:** For the record, my name's Bob
12 Tabor or Robert G. Tabor. I'm from the Fernald
13 site. I'm a member of the Fernald Atomic Trades and
14 Labor Council, a 22-year veteran of that site. On
15 the issue of credibility, I guess the issue would be
16 -- this in my mind is how do you maintain
17 credibility if the contractor supporting the
18 Advisory Board had DOE and/or NIOSH business? To me
19 this is kind of like the Arthur Andersen syndrome or
20 issue. You know, you can't do both. You can't do
21 both audit and consult work -- so to speak, serve
22 two masters. When you have someone in to support
23 the audit process, they will need to only serve one
24 master in my mind and that is strictly audit. That
25 should be their business. They can't be anybody

1 that's beyond -- or they can't be -- you know,
2 nobody can ever doubt their integrity is what I'm
3 really saying here. We need to have somebody that's
4 knowledgeable, somebody that's credible, somebody
5 that's recognized to do this business because the
6 credibility of the Advisory Board and credibility of
7 this process is absolutely -- you know, it's very
8 important. And that basically is my comment.

9 **DR. ZIEMER:** Thank you very much. Any
10 questions for this commenter? Thank you.

11 Shelby, did you have a comment?

12 **MR. HALLMARK:** I just wanted to say since
13 several individuals spoke about difficulties in
14 filing claims or that there were workers at Los
15 Alamos who have felt pressured not to file, my
16 comments earlier were with respect to people filing
17 with the right program, with the DOL program if you
18 had one of the three conditions that we cover, or
19 with the DOE, their worker assistance program if you
20 have other kind of toxic illness. But I wanted to
21 make clear to you, to everyone and then hopefully
22 you will pass the word along to anyone you know,
23 that it is certainly the Department of Labor's
24 position, and I believe the Department of Energy's
25 position, that anyone who has one of those

1 conditions ought to be able to feel free to come
2 forward and file that claim without any reprisal and
3 without any other negative impact.

4 Floyd Archuleta, who is the resource center
5 chief here in Espanola, is charged with helping
6 people file claims, both for the Department of Labor
7 program and the Department of Energy program which
8 is now getting started. And insofar as there are
9 individuals out there who have those conditions who
10 have not come forward, they certainly should utilize
11 those services and make use of this program, which
12 was intended for individuals in those two
13 categories. I just wanted to make that clear
14 because I do think it's important that people have
15 that chance.

16 **DR. ZIEMER:** Thank you. Are there any
17 other --

18 **MR. LADA:** Can I ask you a question, please?
19 Floyd Archuleta of the --

20 **UNIDENTIFIED:** Come to the mike, sir.

21 **DR. ZIEMER:** Please use the mike so the
22 recorders can record your comments.

23 **MR. LADA:** Sir, I understand in this nearly
24 1172 cases have been filed and only nine people have
25 been compensated. Nine people.

1 **MR. HALLMARK:** Ten.

2 **MR. LADA:** Ten people out of 1172. That's a
3 very low number, don't you think?

4 **MR. HALLMARK:** I think it's quite low. I
5 mentioned this in my comments. The reason -- the
6 reason for that is that virtually all the population
7 here at Los Alamos would need to go through -- who
8 would be eligible for the Department of Labor
9 program would need to go through the NIOSH dose
10 reconstruction program, which is what's being
11 discussed here today. That process is just now
12 getting started. Until it's completed for all those
13 individuals who have filed of that 1100 or more, it
14 won't -- 1400, I believe -- it won't -- we won't, at
15 the Department of Labor, be able to complete the
16 work on those cases. So by definition, those cases
17 are still in process.

18 And as I indicated, our office in Denver has
19 had a backlog and we are working to try to reduce
20 that backlog, but the major issue for most of the
21 people here in New Mexico is going to be the NIOSH
22 process and having that process work all the way
23 through.

24 **MR. LADA:** It'll work if NIOSH does not
25 raise the bar. The bar is 15 R. Is this correct,

1 NIOSH?

2 **DR. ZIEMER:** No. In fact, the legislation
3 is not based on a dose number. It's based on
4 whether it's more likely than not that the cancer
5 was caused by radiation, and that actually is a
6 little more complex calculation. It's conceivable
7 that somebody below the dose limit could get
8 compensated.

9 **MR. LADA:** So if somebody -- if it's 50 R --
10 or 50, and it's 49.9, is there going to be bias in
11 that?

12 **DR. ZIEMER:** It's not -- these cases are not
13 decided based on where they are relative to the DOE
14 numbers because the NIOSH folks go back and they add
15 some additional things in. For example, they will
16 add back in if there's dose missing that can't be
17 accounted for, they will add that back in. If there
18 are medical X-rays that were required as part of the
19 work employment that -- and those won't appear on
20 those dose records, those are added back in. So the
21 NIOSH number may be very different from the DOE
22 dose. And the reason for that is the DOE numbers
23 are used to simply control the workplace on an
24 administrative level. These numbers are used in a
25 specific way to compensate people based on the law,

1 where -- so in fact, you simply don't take the DOE
2 dose number and say okay, they're 49.9 so they don't
3 make it and 50 does. It doesn't -- that's not how
4 it works, really. Well, let -- Jim's the expert on
5 this here. I'm answering for you, Jim.

6 **DR. NETON:** I think you've answered the
7 question, really.

8 **MR. LADA:** Well, you know, 'cause a lot of
9 the guys that I talk to say why go for -- through
10 all this, Jerry, you know. And then there is no
11 compensation. And I tell them look, who's going to
12 take care of your family? The cancer's not going to
13 show up till five, ten, 15, 20 years down the road.
14 In fact I just had a friend that just passed away
15 Saturday, Mr. Ernesto Serrano, who was a custodian.
16 He had cancer since '91. So I'm encouraging his
17 family, his wife, to file a claim.

18 **DR. ZIEMER:** And you're quite right in doing
19 that.

20 **MR. LADA:** Yeah. Thank you.

21 **MR. ELLIOTT:** Jerry, I would like to one
22 statement you said about NIOSH raising the bar, and
23 I wish you had -- if you weren't here earlier when
24 we went through some examples of dose
25 reconstruction, I would think if you saw those

1 examples we displayed for the Board today you would
2 see how -- where science takes us and science ends,
3 we start from that point and we're claimant-friendly
4 in every regard that we have. Every step that we
5 take past where science -- the basis of science is
6 used to support the merit of the claim. Anything
7 further -- beyond that, we use a claimant-friendly
8 approach. We're not raising the bar.

9 **MR. LADA:** Okay.

10 **MR. ELLIOTT:** The bar, if anything, is being
11 lowered because where science fails us, we become
12 claimant-friendly.

13 **MR. LADA:** Okay.

14 **MR. ELLIOTT:** Okay. So I thank you for your
15 comments, as always.

16 **MR. LADA:** Well, I know that Ted Katz is the
17 one that came up with the numbers. Right?

18 **MR. ELLIOTT:** Ted Katz?

19 **MR. LADA:** I know he was part of the --

20 **MR. ELLIOTT:** Grady is a health physicist
21 who has done some of the dose reconstructions that
22 were displayed today, yes, but the numbers that
23 you're talking about are dose estimation numbers in
24 the dose reconstruction process -- I assume.

25 **MR. LADA:** Right. What I was talking about,

1 Larry, is that I knew for a military G.I. they used
2 to use five R.

3 **MR. ELLIOTT:** Yeah.

4 **MR. LADA:** So --

5 **UNIDENTIFIED:** Different purpose.

6 **DR. ZIEMER:** Yeah, the five R or the five
7 rem, which is still used today as a working annual
8 limit for workers for external exposure -- well,
9 external plus internal. But that is not the only
10 piece of information that these folks are using. So
11 as a health physicist, which is my background, I
12 would say this is very worker-friendly.

13 **MR. LADA:** Well, as long as you take into
14 consideration all the alpha, the beta gamma, the
15 neutrons --

16 **DR. ZIEMER:** And they do.

17 **MR. LADA:** -- the things they did at 55 and
18 the glow box, the glove changes, you know, all these
19 barrels that went down to over at CMR, 40, THE,
20 lance, take a very good close look.

21 **DR. ZIEMER:** Thank you.

22 **DR. NETON:** Just one last thing. The dose
23 reconstruction itself is issued in draft form to the
24 claimant to review and comment on. Until the person
25 actually reviews it and signs off that we've

1 incorporated anything that they brought to bear on
2 the claim or we have explained sufficiently why we
3 didn't use it, then it won't go forward. So it's
4 not that we will do this thing, this dose
5 reconstruction, and then send it directly to
6 Department of Labor without the claimant's input.
7 There is that safeguard built into the process.

8 **MS. JACQUEZ:** (Inaudible)

9 **DR. ZIEMER:** Sure, you bet.

10 **MS. JACQUEZ:** (Inaudible)

11 **DR. ZIEMER:** No, but we may all leave for
12 dinner. Please proceed.

13 **MS. JACQUEZ:** Can I act as your appetizer
14 then? My dad had readings -- a lot of readings of
15 tritium, plutonium -- and I don't know how to
16 pronounce this, is it americium or --

17 **DR. ZIEMER:** Americium.

18 **MS. JACQUEZ:** Americium?

19 **DR. ZIEMER:** Right.

20 **MS. JACQUEZ:** -- among others, but many
21 times he was close to this tritium and I'm to ask
22 you as a scientist, was this used to build atomic
23 bombs or is it...

24 **DR. ZIEMER:** Tritium -- I guess -- since I
25 don't know any of the secret stuff, I'll just tell

1 you -- well, it's certainly a well-known fact that
2 what we called the hydrogen bomb -- tritium is
3 hydrogen 3 and the hydrogen bomb, as a component,
4 has tritium in it. If you want details on how to
5 make one of those bombs, you can read the -- yeah, a
6 web site -- no, the novel by -- huh? Well, Howard
7 Moreland, but -- I am having a senior moment on the
8 writer that -- the *Hunt for Red October* guy --
9 Clancy. Read Clancy's book, you know. It has more
10 detail than anyone wants to know. Thank you.

11 **MS. JACQUEZ:** But anyway, those are the --
12 that's what he --

13 **DR. ZIEMER:** Sure.

14 **MS. JACQUEZ:** -- had high readings in and,
15 to me, that's -- that's -- I mean plutonium?

16 **DR. ZIEMER:** Hopefully that should show up
17 in his records and --

18 **MS. JACQUEZ:** It is. It's written down
19 several times.

20 **DR. ZIEMER:** Do we have any further comments
21 from the public? Yes, ma'am -- and identify
22 yourself again for the record.

23 **MS. ERINS:** Good afternoon. My name is
24 Joanie Erins. I'm the waste programs director for
25 Concerned Citizens for Nuclear Safety here in Santa

1 Fe, New Mexico. And in May of 2002 we commissioned
2 a report by Steve Wing and David Richardson, who are
3 epidemiologists from the University of North
4 Carolina, entitled *Occupational Health Studies at*
5 *Los Alamos National Laboratory*, and I would -- I
6 don't know if I have enough copies for everybody,
7 but I thought I would provide this as an example of
8 a review that was done of the occupational health
9 studies at LANL, obviously. But also it talks about
10 the -- most of the people that were studied were the
11 white UC workers, the University of California
12 workers, as opposed to (inaudible) workers, and this
13 may help move this process along further. So thank
14 you.

15 **DR. ZIEMER:** Thank you very much. Any
16 further comments? Yes?

17 **MR. ARCHULETA:** If I may, I'd just like to
18 take a minute to introduce --

19 **DR. ZIEMER:** Please identify your--

20 **MR. ARCHULETA:** -- myself.

21 **DR. ZIEMER:** Oh, you were --

22 **MR. ARCHULETA:** Yes, my name is Floyd
23 Archuleta. As Shelby mentioned, I'm the manager at
24 the resource center in Espanola, and we also -- you
25 know, we have three large facilities that we're

1 responsible to, the Sandia National Laboratories, as
2 well as Los Alamos and also PanTex in Amarillo, and
3 other smaller facilities in New Mexico. And we try
4 to be a true resource to our claimants. We assist
5 them with our staff of caseworkers in taking their
6 claims. But also there's plenty of follow-up work
7 that needs to be done after the claims are followed
8 -- or are filed, and so we're there to be, like I
9 said, a true resource to them. We try to become as
10 involved as we can, even in the NIOSH process.
11 We've had requests to serve even as translators or
12 interpreters through the interviews because a lot of
13 our people don't speak Spanish -- or English
14 fluently, and so we -- our caseworkers do. And so
15 again I'd like to make that offer to you.

16 We have an office in Los Alamos at the
17 Laboratory that we're staffing twice a week. Los
18 Alamos has been very cooperative with our office in
19 sharing facilities with us, and so we're taking them
20 up on that and also we're using the facilities at
21 Sandia in Albuquerque to -- again, to make ourselves
22 available to potential claimants there, as well.

23 So again, welcome to New Mexico, and we're
24 there to do -- try to promote the program and make
25 it available to as many workers as can benefit from

1 it. Thank you.

2 **DR. ZIEMER:** Thank you very much. Okay --
3 yes?

4 **MR. HAGER:** My name is Rob Hager and I'm an
5 attorney and I've litigated -- well, both the Karen
6 Silkwood case and the Harding case in Paducah, and
7 I'm going to be very brief. I'm not going to make
8 an opening argument here. In the Harding case we
9 had an opportunity to put into evidence Steve Wing's
10 study at Oak Ridge, and I heard earlier some talk
11 about using the bomb data for doing dose
12 reconstruction. I strongly urge taking a close look
13 at Steve Wing's work. That's all I have to say.

14 **DR. ZIEMER:** Thank you very much. Any
15 further comments? If not, we're -- oh, yes, Larry.

16 **MR. ELLIOTT:** I feel that it's important for
17 everyone's understanding for me to say something
18 about the dose reconstruction contract award and
19 this -- the many things that have been said about
20 conflict of interest here today. I want you to
21 understand that there are two types of conflict of
22 interest that we're dealing with here.

23 One is an apparent, obvious conflict of
24 interest. That would be where someone serving in
25 the position, through their own influence and self-

1 motivation, commits an act that influences the
2 outcome adversely. Our goal is to have zero of
3 those. No obvious adverse outcomes due to conflicts
4 of interest.

5 The second type of conflict of interest that
6 you need to understand and be aware of is one called
7 perceived conflict of interest, and that is I think
8 what everyone is talking about here today. And that
9 is where an individual, by former affiliation, has a
10 perception -- gives a perception to the general
11 public that they could -- they could -- commit an
12 act that would be a conflict of interest, just
13 because they have served or they have been involved
14 or they have been affiliated in some shape or form
15 that would allow them to do that.

16 And so I want you to understand what we're
17 trying to do here is to control for no apparent
18 conflicts of interest that are distinct. We're
19 dealing and controlling as best we can with our ORAU
20 team perceptions about conflicts of interest, and I
21 think that's -- the latter is what everybody seems
22 to be talking about and I want you to be aware that
23 there are two here and we're trying very hard to
24 deal with both and we have goals set for both.

25 **DR. ZIEMER:** It's now time to recess until

1 tomorrow. Our session tomorrow -- the technical
2 session -- formal session begins actually at 8:30.
3 The schedule shows us as convening at 8:00 o'clock.
4 That's a time to chat informally, get a cup of
5 coffee and get squared away and ready for the day's
6 activities, which will kick off at 8:30.

7 Let me emphasize, in case it was
8 misunderstood, these are open meetings. No one is
9 excluded. Everyone is free to attend as much as
10 they can stomach of the Board's deliberations --
11 that wasn't a good word to say, but you understand.
12 It's getting that time of day where -- but please do
13 not feel excluded. Everyone is welcome to attend
14 and we do value input from all.

15 So with that, we will recess for the day.
16 Thank you very much.

17 (Meeting adjourned 5:15 p.m.)
18
19

C E R T I F I C A T E

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STATE OF GEORGIA :
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COUNTY OF FULTON :

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the 15th day of October, 2002; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 17th day of November, 2002.

STEVEN RAY GREEN,
CERTIFIED MERIT COURT REPORTER
CERTIFICATE NUMBER: A-2102